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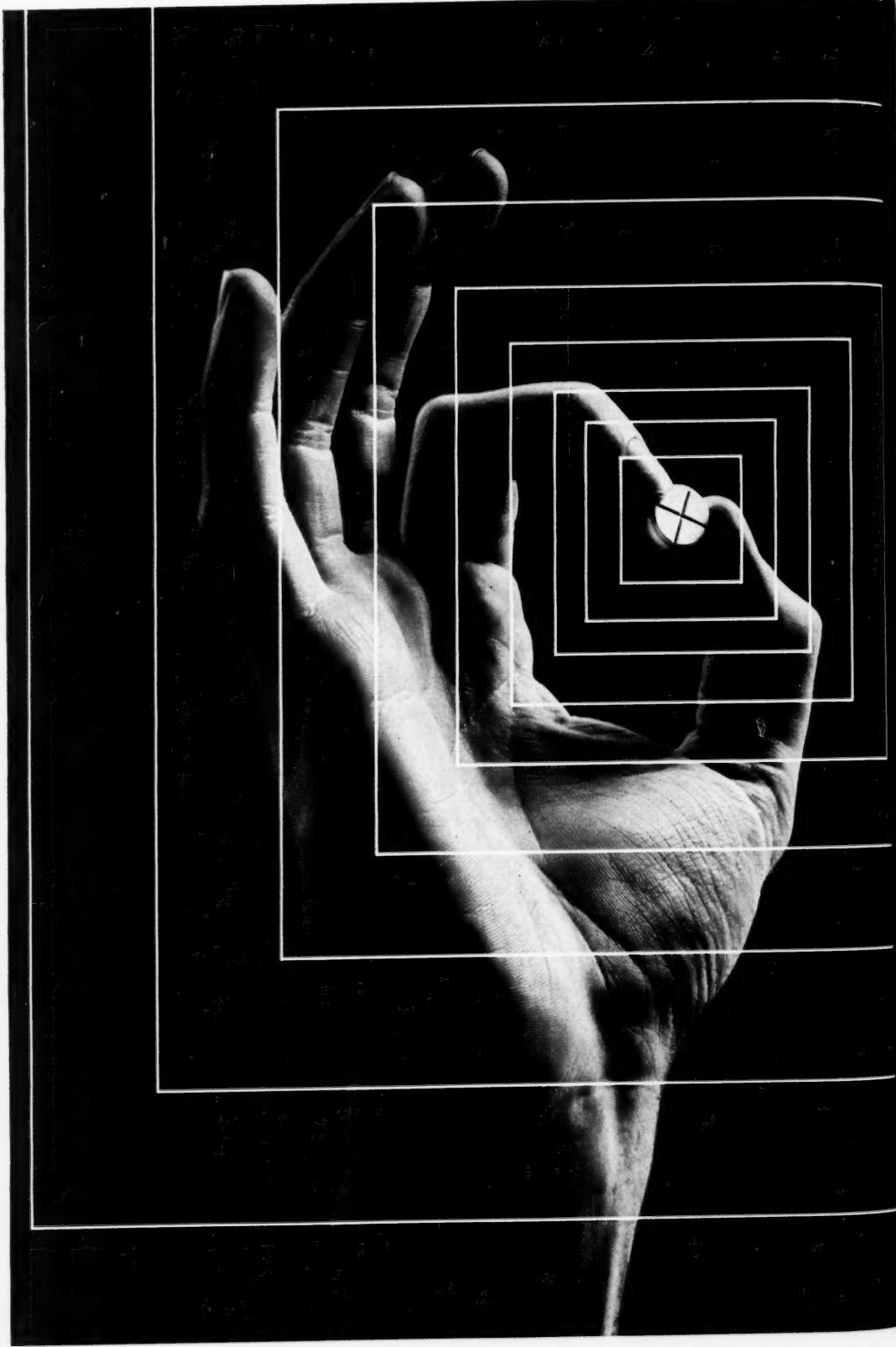
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The RHODE ISLAND MEDICAL JOURNAL

VOL. XLI

MARCH, 1958

NO. 3

THE CARE OF THE SKIN

FRANCESCO RONCHESE, M.D.

The Author. *Francesco Ronchese, M.D., of Providence, Rhode Island. Clinical Professor of Dermatology, Emeritus, Boston University Medical School, Boston, Massachusetts.*

THE SKIN may be compared to a suit, with the difference that it cannot be shed and hung in the closet, nor sent to the tailor for renovation, nor can a new one be purchased.

The importance of the skin for life and welfare is illustrated by two simple facts. A human being cannot survive the destruction (by fire) of one third of his skin nor the varnishing of the entire body with a substance sealing the pores, a thing which prevents the all-important function of sweating, by which the internal temperature of the body is regulated. Oil from the oil glands lubricates the skin and keeps it supple. When the supply of oil declines, as in the approach to old age or in certain diseases, the skin becomes defenseless and scales and cracks. Teen-age boys and girls who complain loudly of the "unsightly" greasiness of their skin and hair should remember this point.

The term *normal* is rather indefinite. Roughly, one can indicate as normal the skin which stands abuses which another cannot. When we come into the world, we know nothing of our past or future. Normalcy or abnormalcy has been bequeathed to us generations ago by some early couple. Take common baldness, for example. The shiny, clean, hairless top of the head, noticeable in half the male population, has resulted simply because those men picked the wrong ancestors. Science has not yet found the reason for it, and consequently there is no remedy for it. The great amount of money spent in establishments that "guarantee" to cure common baldness could serve a much better purpose.

The skin of the hand may be compared to a rubber glove. The surgeon's hand, protected by an unbroken rubber glove, can probe deadly, germ-ridden wounds without being harmed. Theoretically, a normal hand without scratches, cuts, or

bruises can be immersed in a culture of virulent germs with impunity. But, if there are scratches, cuts or bruises, the virulent germs will find their way to the internal organs through these cuts and nicks.

The normal hand can also endure over-cleaning and over-scrubbing. During the period of rest new layers are produced to replace the one scraped, as, for example, razor-damage of the face is repaired. But if the hand is not normal, it has less oil, and becomes dry and cracks either congenitally or by disease, such abuse is not tolerated. Hence it will become red, itching, swollen, oozing, blistery . . . the picture of dermatitis or eczema, which proceeds through the various stages from acute, to subacute, to chronic.

The same is true of the body-passages. The canals of the ears only very rarely need a cleansing. Most of the damage, which later becomes acute dermatitis (otitis externa), popularly called a fungus infection, is due to uncalled-for removal of wax. This starts the itching, in predisposed individuals. Cleansing and scratching give pleasure, so the person keeps on digging until serum and blood run. Then it becomes very difficult to stop scratching. Later the serum and blood dry up and act like tiny spikes, starting the itching again, and so the cycle commences anew. The case is the same for other body-passages. There is no itching of the anus or of the vulva in so-called uncivilized people, who have no modern facilities in their powder rooms. The shepherd in the mountains uses no refined tissue paper after his bowel movements. He uses nothing, but then, too, he has no ambitions or financial worries. *Pruritus ani* and *vulvae* is unknown to primitive people. Generalized *pruritus*, especially of the old, is often stopped by the discontinuance of the daily bath and avoidance of soap. What is popularly known in the so-called civilized countries as "athlete's foot" is unknown among the barefooted peasants or soldiers of so-called uncivilized countries. Most cases of itching and blistering of the feet are contact dermatitis from one or a combination

continued on next page

tion of the seventy-odd kinds of materials going into the manufacture of a shoe. Not wearing shoes for a few days often is the best remedy.

Care of the Hands

To return to the hands, an example of normal *versus* abnormal condition is offered by the hands of the laborer, which are rough and thick with the underlying structures protected and work permitted without discomfort by the natural formation of the calluses. His hands are perfectly healthy in spite of the fact that he treats them as roughly as his shovel.

Another example is the professional dishwasher, who has the hands of a baby in spite of day-long contact with modern household cleansers which are most efficient for pots and pans but very destructive to an abnormal skin. Machine oil, soda water, electroplating fluids and textile dyes are also very hard on the hands.

Normality or immunity, or hardening however, should not be abused. Excesses of all kinds are punished in the end. Example: the man who boasts that he is immune to poison ivy and can pick it with bare hands and even chew the leaves, may one day find himself covered with the most severe dermatitis from this same poison ivy. Most likely because nature, tired of his boasts and his body, tired of producing immunity, left him without defense.

The obvious advice is then: do not abuse your skin and go easy on handling potentially harmful chemicals. Sometimes a person can manage to harden his skin, but it is generally difficult to do so.

If a person has abnormal hands, he should protect them with gloves. Dry cotton gloves should be used for dry work in order to lessen the necessity of scrubbing afterwards. For wet work, cotton gloves should be put on first and over them, rubber gloves. Rubber is itself a sensitizer, as it prevents evaporation, and so sweat accumulates under the rubber, thus turning defense into offense.

There is good reason for smearing greasy substances on the hands for protective purposes since the dirt mixes with them and since more of the same material can be used to wipe off the accumulated dirt and smeared grease.

Do not try to make honorable working hands look like those of the person of leisure or like those of professional men by scrubbing and scrubbing. Reserve soap for those parts for which it is mostly indicated, viz. the fingertips while handling food.

Sun Exposure

The pigment or color of the skin has been put there by nature to protect the body from an excess of sunlight. Brunette skin tolerates summer sun well; blonde skin, poorly. So exposure at the beach should proceed gradually, by being increased a few minutes every day and with the use of oil. First, try your protective lotion on a small area on your

body if you do not want to risk cutting your vacation short because of the sensitivity of your skin to the lotion you have bought to protect you from the sun.

Examples of damage from excess of sun, always in predisposed individuals, are the weather-beaten skins of farmers, sailors and fishermen. Many skin cancers are due to excess of sunlight. In predisposed individuals excessive exposure to sun, instead of favoring the growth of hair, makes it fall out more quickly. For example, lifeguards often become prematurely bald because they are constantly exposed to the blazing summer sun.

Sweating is a natural function, necessary both in good health and in sickness, but when it becomes excessive, as in certain localities like the armpits and feet, it may become a nuisance. Frequent washing and powdering help, as do weekly shaving and the wearing of washable clothing next to the armpit. Since anti-perspirants and deodorizers may have the same effect as a sun-protecting lotion, test them on small spots before smearing them all over. The use of baking soda may be effective and may save spending money on fancy patent medicines. The chlorophyll concoctions have proved a great boon to the manufacturers but not to those who suffer from obnoxious smells. Make sure the obnoxious smell is a reality and not a product of the imagination.

The man who suddenly develops poison ivy after years of immunity brings up another problem, as does the woman who after dyeing her hair for years suddenly finds herself with a tremendous dermatitis, swelling of the face, closing of the eyelids, etc. Cases of loss of sight from poisonous hair dyes have been reported, the result of lost immunity or of the use of a different chemical. Mixtures are always changing, and patch-testing is never one hundred per cent reliable. Persons with old faces who seek teen-age colors may be justified by the eternal and unquenchable search for the fountain of youth, but what shall one say of the teen-agers who dye their hair?

It is deplorable that so many people of average or poor means spend so much money on fancy creams, lotions, hair tonic, "skin foods," etc. To say that it makes jobs for the working class is no justification, for it often makes millions for swindlers. When a pound of vaseline costing a few cents is flavored with a few drops of inexpensive perfume or cold cream, plus a little bit of cheap coloring matter, and is sold for 2 or 3 or even 5 to 10 dollars, just because the jar is fancy, the label is golden, the slogan is French, it is no longer vanity, it is plain gullibility.

Mixtures sold without indication of what is in them are not approved by the Council of Drugs of the American Medical Association. This group pro-

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EXAMPLES OF IMPROPER CARE OF THE SKIN



FIGURE 1

To rid himself of imaginary bugs crawling on his skin (delusion of parasitosis) the man poured undiluted sulphonaphthol on his back.



FIGURE 2

A common mild case of herpes simplex (fever blisters, cold sores) is treated with ammoniated mercury ointment, producing a dermatitis medicamentosa which will make a disorder usually involuting in one week to go on for several weeks.



FIGURE 3

An irreparable loss of hair is the result of a chemical burn from a permanent wave solution.



ASTHMA IN INFANCY*

WILLIAM P. BUFFUM, M.D.

The Author, William P. Buffum, M.D., of Providence, Rhode Island. Consultant to The Allergy Clinic, Rhode Island Hospital, Consulting Pediatrician, Charles V. Chapin, Miriam, Providence Lying-In hospitals, and Memorial Hospital, Pawtucket.

MY SUBJECT is asthma in infancy. At this time, asthma has some characteristics that are not found in later childhood. It is these characteristics, peculiar to early life, that are considered here; I have taken the first two years as the period of early life.

1. Respiratory infections seem to be of even greater importance than in later years. The commonest type is the baby who wheezes only with "colds."

2. The typical wheezing with prolonged expiratory phase and a musical sound is not always found; babies under six months of age often have only a loud tracheobronchial rattle.

3. It has been said that, when it first occurs, asthma is always paroxysmal, with a return to normal breathing in a few days. This is not necessarily so in infancy; it is not at all uncommon in the first year of life for the wheezing to begin and continue steadily for a month or more.

4. Of my patients under two years of age, 60 per cent gave entirely negative scratch tests. I believe that my list of patients contains an undue number of severe cases, and that an average list would show negative scratch tests in perhaps 75 to 80 per cent.

5. The severity of the asthma and the difficulty of the treatment may be indicated by certain signs.

(a). A strongly positive scratch test to egg is an almost certain indication of a difficult time ahead. One quarter of my babies with asthma had strongly positive egg tests. These patients had a difficult time and in general are still wheezing. You will find that a high percentage of your difficult cases began before the age of two, and if tested at that time, had a positive egg test. One is tempted to theorize that these babies are so liable to sensitization that

the egg eaten by the mothers sensitized them *in utero*. I think this is of practical importance; it makes it mandatory to test an asthmatic baby at the first opportunity. Positive scratch tests, especially to egg, indicate a high degree of sensitivity, the probability of multiple allergies, and the necessity for prompt, vigorous treatment.

(b). The presence of atopic dermatitis in a wheezing baby has about the same prognostic import as the positive egg test. A mild eczema indicates the probability of a troublesome case; a severe eczema means certainly that we are in for a lot of asthmatic difficulties.

(c). Conversely, if we find no positive scratch tests, including egg, and if there is no atopic dermatitis, then it is highly probable that the asthma, with proper treatment, will clear up rapidly.

6. It is notable that patients with negative tests not uncommonly develop positive tests later. It is much more striking that patients with positive food tests at first testing, develop positive inhalant tests later. In other words, certain babies are especially liable to sensitization, have sensitivities to foods first, and later to inhalants.

It is also evident that most foods that cause wheezing do this in the group of severer cases, those with many positive tests. It is much less common to have a food cause wheezing in a baby with entirely negative scratch tests.

7. Recurrent attacks of wheezing or continuous wheezing almost always mean asthma, but other conditions must be excluded. This is done by the acumen of the physician, with the support of certain diagnostic procedures, selected according to the nature of the case. For instance, in cases of continuous wheezing with malnutrition or loose stools, pancreatic fibrosis must be carefully considered. In any case of continuous wheezing congenital anomalies of the blood vessels and of the respiratory tract must be thought of. The possible presence of a foreign body should always be kept in mind. In general, most mistakes are made because the physician does not even consider the diagnosis concerned. I believe that every wheezing baby should have an X ray of the chest, a white and differential count, and a tuberculin test.

The term asthmatic bronchitis is widely used by

*Presented at the postgraduate course of the American Academy of Allergy, at Philadelphia, Pennsylvania, February 1, 1958

physicians, but with different meanings. Some use it to indicate a true bronchitis, often with pneumonitis, occurring with fever and prostration. Some use it as a diagnosis for asthma occurring with a respiratory infection. Some call asthma, with negative skin tests, asthmatic bronchitis. Others use this term for the first two or three attacks of asthma, to satisfy the parents. It seems to me that this is one of those indefinite diagnoses that should, for the sake of clear thinking, be avoided.

8. The prognosis in asthma, occurring before two years of age, is probably distinctly worse than when the asthma begins later. A very high percentage of all severe asthmatic cases in children gave a history of wheezing before the age of two; and a follow-up of wheezing babies shows nearly 50 per cent still wheeze, at least occasionally. The more severe ones tend to become chronic asthmatics. We must take these cases seriously and do the best with them that we can.

9. The principles of long-term treatment are the same as those in later childhood. Allergies which are causing the trouble, both inhalants and foods, should be avoided as far as possible. Inhalants which cannot be avoided entirely are combatted by injections. Vaccines are used in those cases that seem to be due largely to infections, and especially where no inhalants have been incriminated.

I have found no great differences in the reactions to injections between the babies and the younger school children. The babies rarely have violent constitutional reactions. I have never seen one; but babies are easily made worse by overdosage.

My final word of advice is to treat these patients *promptly and thoroughly* and to *keep at it*.

THE CARE OF THE SKIN

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tects the public against the unwarranted claims forced on it by slick advertisers. The intelligent layman should understand that the advertisements in newspapers and over the radio and television of youth-restoring creams, of pimple-curing specialties, or of cures for incurable diseases are just plain bait for . . . the unfortunate fish.

Hair and Scalp Problems

The hair may be a cause of distress, when too thin, too brittle, or too oily, or when its color changes, but the nails are a necessity to the worker. Brittle, fragile, thin or splitting nails are a liability. To get the most out of constitutionally poor nails a person must do what he does for the other parts of defective hands, viz., limit the soap to the minimum and protect the fingertips with gloves.

The proper diet for the skin is a simple, wholesome, balanced one. Some skin conditions are asso-

ciated with overeating, improper digestion, poor elimination and constipation. Oiliness of skin and scalp may result from indulgence in excessive amounts of fats and starches.

The hair may offer some protection against heat or cold. Laborers who have heavy beards and whiskers have an actual filter on the nose and mouth, which affords their lungs considerable protection from dust, thus reducing considerably the incidence of disease of the lungs. But which present-day worker will give up his clean-shaven face for health's sake?

Like the skin, a dry scalp demands little soaping and more oil, while an oily scalp demands plenty of soap and no oil. Recently, a query in the *Providence Journal* information column asked where the hair made into wigs comes from. The answer was that the finest quality comes from mountain villages of northern Italy where women never wash or dye their hair, but keep it clean by brushing and combing alone. What a financial collapse if the women of the world decided to follow the custom of the uncivilized mountaineers.

The care of the hair can be summed up as follows: the only way of keeping normal hair clean is by washing it with soap and water. The air pollution of our cities compels us to the use of soap. Pure castile soap or tincture of green soap is the best. This treatment requires time, but no lotion is better for normal healthy hair than soap and water. Normally, it should be washed at least once a week.

Salt water does no harm to the hair, but it is advisable to rinse it with fresh water. Bathing caps usually interfere with a normal circulation.

Massage of the scalp, morning and evening, should become a habit just as much as brushing the teeth. Each member of the family should use his own comb and brush. The hair should be brushed every day, but gently, with soft brushes and not with "100 strokes."

In shampooing, a thick lathering of soap should be followed by a thorough rinsing with cold water and then by drying with warm towels. It is reasonable that women with long hair need special operators to wash their hair, but certainly this does not apply to grown men.

MONDAY, APRIL 7 . . . 8:30 P.M.

Meeting of the

Providence Medical Association

MASTERS IN MEDICINE — ON CERTAIN MINOR INJURIES OF THE BRAIN*

Being the Annual Oration, Medical Society of London

by

WILFRED TROTTER, M.S., F.R.C.S.

Surgeon and Holme Lecturer in Clinical Surgery, University College Hospital

Introductory

THE CHOICE of the subject upon which I am to have the honour of speaking tonight has been guided by two considerations. In the first place, the unity of structure which is so characteristic a feature of our society seemed to point towards some topic of which the interest is not limited to any special department of medicine. In the second place, the occasion appeared to be one, if I rightly interpret its tradition, in which a very close restriction to technical matters need not be insisted on; while, if the subject chosen developed naturally towards regions outside the strictly medical field, some glance into such wider sources of interest might be, in the circumstances, legitimate.

It will, I think, be admitted that the subject of head injuries is of practical interest and importance to the great majority of us, whether our work lies exclusively or chiefly in a special department of medicine, or is distributed over all. It is, however, only to a very much limited part of this large subject that I propose to invoke your attention. My primary object will be not the gross and at the same time relatively definite conditions that we meet with in immediate consequence of obviously formidable accidents, but the conditions at first sight relatively indefinite, and not obviously serious, which occur as late results or sequels to head injuries of all grades of severity. It will be convenient at once to define our subject yet more exactly. We are to consider a group of phenomena, including headache, giddiness, and other less definable sensations in the head, defects of memory, concentration and attention, alterations of disposition and mood, and certain kinds of mental deterioration. This group of phenomena is to interest us when arising after, and in obvious consequence of, a head injury. It will not be necessary to deal with each member of the group, as the single one of headache can be selected as the most characteristic, and as fully representative of the others. What can be said of headache, the commonest of them, can be said with all reasonable probability of most, if not all, of the others. We have now pruned down our subject until it is ade-

quately represented by that of headache as a sequel of head injury. There remains, however, one further stage of definition to be accomplished. Headache, and others of the associated group of symptoms, is common as a sequel to head injuries of all grades of severity, and bears no obvious relation to the amount of gross destructive damage that has been inflicted. In considering its significance here, therefore, it will simplify the problem if we limit ourselves to headache occurring as the sequel of head injuries of minor severity, and without evidence of local damage to the brain, either through destructive injury or in consequence of haemorrhage. It might be thought that these restrictions of our subject have reduced it to insignificance. This is, however, far from being the case, and it is often of utmost practical importance to recognize the fact that seriously disabling headache is a common sequel to head injuries of an apparently minor kind, in which evidence of any direct local injury of the brain has been altogether lacking.

We have, then, ultimately before us the subject of serious headache as a sequel of apparently slight or trivial head injury.

Headache as a Sequel of Minor Head Injury

It is quite a mistake to suppose that the conditions we are considering are clinically indefinite and difficult to recognize. In well marked cases one of the most fully characteristic of clinical pictures is produced.

The Causal Injury

There are two types of accident which fulfil the conditions we have laid down. Both are fairly common, of quite moderate severity, and seem at the time of infliction to have caused no definite or severe cerebral injury. In fact, the mildness of the whole affair often causes both patient and doctor, if one is consulted, to congratulate themselves on no harm having been done, and to ignore the necessity for precautionary treatment.

In one type the accident is a fall on the head, as, for example, from a horse. The patient develops slight concussion of the brain; there is momentary unconsciousness, which is quickly recovered from,

*Reprinted by permission, from the BRITISH MEDICAL JOURNAL, 1:816-19, May 10, 1924

and followed by dizziness and headache, which clear up in a comparatively few hours. I may say at once that I use the term "concussion," as I think it should only be used in the strict classical sense to indicate an essentially transient state due to head injury which is of instantaneous onset, manifests widespread symptoms of a purely paralytic kind, does not as such comprise any evidence of structural cerebral injury, and is always followed by amnesia for the actual moment of the accident.

In the second type of injury the violence is characteristically limited to a localized area of the skull. This may be produced by the patient accidentally running against some obstacle, by a blow from such a weapon as a stick or sword, or by the grazing impact of a bullet. In these cases concussion is characteristically absent; there is no loss of consciousness, and the patient retains a clear memory of the moment in which the injury was received. If the blow was over some part of the brain, slight functional disturbances in which are capable of being manifested in symptoms, there may be transient numbness, and tingling in the corresponding limb, or clumsiness in the use of it. Such phenomena are not relevant to the limited subject we are considering, and perfectly characteristic cases of post-traumatic headache commonly occur without them.

We have then a patient who has sustained one or other of these accidents. He has been shaken and is in some discomfort for a few hours, or even a day or two, but has already begun to feel that, ugly as the affair seemed at the moment, no harm has been done, and then he begins to suffer from headaches.

As I have already said, I take headache as a representative symptom, ignoring for our present purpose the constellation of minor manifestations of which it is undoubtedly the most important and outstanding figure. It is necessary now to define the clinical characters of these headaches.

Clinical Characters of Traumatic Headache

Onset—If headache has been a well marked immediate consequence of the injury it may be continued into the sequela headache we are considering. If the patient has been laid up as the result of the injury, the headache is apt to come on when he resumes active life. In any case it is often a week or two before the patient realizes that he is faced with a distressing and disabling trouble that shows no tendency to early spontaneous recovery.

Occurrence—It is usual and almost characteristic for the headache to occur in attacks which last for periods varying from a few hours even to two or three days. Between attacks the patient may feel absolutely well in every way. The attacks are apt to be brought on by physical exertion, severe or prolonged, or by mental excitement, anxiety or fatigue, and by such combined influences as walking in

bright sunlight or in crowded streets and the many, not always obviously exacting, activities of town life.

Quality of the Headache—The pain is of a severe throbbing, bursting character. Like that of migraine, it is made worse by any effort, and by bright light or loud noise. It may prevent the patient from sleeping, but, like many other kinds of headache, is often brought to an end by prolonged sound sleep. During the attack the patient is usually restless, intolerant of company or of any kind of attention, and irritable. In severe cases, there may be during the attack almost maniacal irritability and sometimes a semi-delirious excitement. The severest attacks do not usually last more than a couple of days.

Results of Physical Examination—It is possible, and indeed quite common, for these symptoms to occur without there being any physical signs of definite brain injury, such as even the minor grades of sensory disturbance of cortical type, defects of finer motor co-ordination, or alteration of reflexes. There is, of course, nothing in the nature of the cases to prevent such a severe grade of injury being present as would produce these signs, but I wish to put emphasis on the statement that many cases of the typical headache are met with in which no physical evidence of brain injury is to be made out.

Pathology

It has sometimes been supposed that these symptoms are due to a psychoneurosis determined by the injury. Such an opinion has found support in the total absence of objectively discoverable evidence of cerebral injury, in the fact that the symptoms tend to subside under rest and easy conditions, and to be aggravated on the resumption of active life, and in the supposed fact that head injuries are particularly apt to lead to the so-called traumatic neuroses.

I need not criticize this hypothesis, as I shall immediately be setting before you what I regard as a definitely established organic pathology; but I may pause a moment to remark on the conception that traumatic neuroses are especially likely to follow head injuries. It seems probable that an injury is related to the neurosis it determines as a painful and terrifying experience, the memory of which does not lapse in the normal way but becomes associated with other unassimilated memories and repressed impulses. It is clear, therefore, that the survival of an actual memory of the accident is an essential factor in the production of a neurosis. Now in a large proportion of cases of head injury (including a considerable number of the special group of cases we were considering) the onset is with concussion, and therefore, since a localized absolute amnesia for the accident is always pro-

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duced by concussion of the classical type, there is no memory at all of the occurrence of the injury. This conclusion is supported by actual clinical experience, which thus confirms the view implied above, that the concussion amnesia is a true organic absence of memory caused by cerebral disturbance.

There can be little doubt, however, that these traumatic headaches are due to definite organic disturbance within the skull. The immediate pathology of headache in general, by which I mean the actual mechanism by which it is produced, has not been the subject of very much attention, though the facts available admit of a reasonably probable sketch being made. In the first place, there is no reason to suppose that disease or injury of the brain itself can be the immediate cause of headache, in the strict sense of the term. As with other serous cavities, the contained organ itself is relatively, if not absolutely, insensitive, and pain can be aroused only by disturbances of the lining membrane and its septa. As with other serous membranes also, it is probable that the most effective pain-producing stimulus is stretching. Now the arrangement of the dural septa is such that variations in the amount of intracranial pressure and inequalities in its distribution tell on them by causing alterations in tension. Thus it comes about that headache of organic origin is a direct expression of disturbances of intracranial pressure however these may be produced. Such a conclusion is in obvious agreement with clinical experience. It is probable that in nature a reduction in intracranial pressure is but rarely the cause of headache. It is plain, however, from the arrangement of the dural septa that a local reduction in pressure can give rise to painful stretching, until the disturbance has become equalized. This, of course, is the mechanism by which is produced the headache that often follows the withdrawal of fluid by a lumbar puncture.

When a disturbance of intracranial pressure is severe or rapidly progressive the consequent headache is continuous. When the disturbance is moderate, and either stationary or only slowly progressive, the headache is apt to be only paroxysmal. This latter is the case with a certain number of slow-growing cerebral tumours in their early stages, and, as we have seen, is almost characteristic of traumatic headaches. As to the nature of the disturbance in the case of traumatic headaches, we have a large body of direct evidence observed at operations. On such occasions there is always some increase in the intracranial tension, but usually this is only moderate in amount, since an operation is not likely to be undertaken during the actual course of an attack. This increase of tension is associated with one or other of two conditions of the brain itself. In cases where the headache has followed an

injury causing concussion, the brain is oedematous and exudes an undue amount of fluid when exposed. In cases where the headache has followed a localized blow on the head and the region struck has been explored, the brain shows by its swelling and blood-staining that it is the seat of a localized bruising. It is highly probable, therefore, that in both cases the increase of intracranial tension is due to the brain being swollen as the result of bruising—in one type of case probably throughout its substance, in the other type chiefly at any rate at the point struck. If it be granted as reasonable to ascribe traumatic headache to a disturbed intracranial tension consequent on bruising of the brain, three points yet remain somewhat obscure and in need of discussion. These are the long persistence of the symptoms and the mechanism by which the bruising of the brain is produced.

The Persistence of Cerebral Contusions

Traumatic headaches are notoriously capable of persisting for many years, and a difficulty at once presents itself in supposing them to be due to a mere bruise of the brain. This difficulty can be met only by the recognition of a very important, and perhaps the only really special, principle of intracranial pathology. This principle is concerned with the unique status of the brain as the one organ in the body enclosed by a capsule which is wholly inextensible by any physiological force. When any other organ is contused and its substance distended by extravasated blood it can swell as a whole practically without limit, so that its circulation can be liberated from embarrassment by pressure, and the effused blood carried away relatively soon. Again, it is possible for such an organ, only very slowly, or perhaps never, to regain exactly its normal size, and yet in no way to be for this reason a cause of symptoms.

Neither of these possibilities is open in the case of the brain. Enclosed within its inextensible capsule, the skull, the organ can undergo compensatory swelling only to a strictly limited extent. The result is that the circulation through a contused area remains embarrassed by the extravasated material present in it, and resolution by absorption of the bruise is indefinitely prolonged. It is surprising how long after the injury the signs of contusion will remain evident in the injured area. I have myself exposed by operation an area of brain that has been bruised by the glancing contact of a bullet with the skull no less than four years earlier. The brain showed a bruise that appeared as fresh as if it had been inflicted within a few weeks. This inordinate and unique delay in the resolution of contusions is fully adequate to account for the striking persistence of traumatic headaches.

The Intermittence of the Symptoms

Although the skull encapsulates the brain with a certain closeness, it does not do so so closely but what a margin of accommodation is left which permits freely of the variations in the size of the brain due to the circulatory mechanism. An encroaching lesion, therefore, such as an early tumour or a moderate contusion, may have its effects, as it were, contained entirely within this marginal space as long as the circulatory movements are tranquil and small. The moment, however, that such movements become active the fact that the intracranial space is actually encroached upon becomes manifest in an evident elevation of the intracranial pressure and consequent symptoms. Patients at such a stage often observe that every repetition of an act like stooping, which, of course, raises the venous pressure and expands the brain, causes a momentary qualm of dizziness and headache. Along such lines as these are to be explained the intermissions in the symptoms of unresolved contusions without improvement in the actual condition itself and the mode of action of the various causes that precipitate the attacks.

Mechanism by Which Cerebral Contusions Are Produced

We have spoken of the complete rigidity of the skull in relation to forces of physiological magnitude. We must now turn to its entirely different behaviour in relation to forces of another order. It seems natural to think of the skull as a very strong shield and enclosure of the brain, which yields only to extreme violence, and only when it is broken. The natural result of the attitude is to put fractures of the skull into a position of primary importance, and to treat injuries of the brain as mere complications of them. This conception is, of course, nowadays quite exploded, and I refer to it merely that, by calling attention to the relative pathological insignificance of fractures of the skull, I may give emphasis to the importance of head injury without fracture.

In relation to forces of adequate magnitude and kind the skull behaves as a yielding and highly elastic structure, capable of undergoing considerable distortion and recovering its form without fracture. It is this property which permits of the occurrence of a whole range of important cerebral injuries altogether apart from fracture of the skull. It is out of the question that we should enter here upon a discussion of the many hypotheses that have been produced to explain the various intracranial effects of violence applied to the head. It would also be useless, since there can be no reasonable doubt that the essential primary mechanism in almost all cases is distortion of the skull.

The skull is apt to be distorted in two different

ways. One is the result of a fall on the head when the cranium is compressed between the surface the patient lands on and the weight of the body conveyed to the base by the spine. In this case a general deformation occurs, diminishing the volume of the cranial cavity as a whole, and causing the acute compressive anaemia which is represented, clinically by the instantaneously on-coming paralytic phenomena known as concussion. The second type of distortion is a local deformation due to a localized blow on the head. Here, of course, there is no general squeezing of the brain and no concussion. In both forms of deformation the brain is apt to be bruised, and when this occurs without fracture of the skull and without other cerebral injury we may get the pure form of traumatic headache due to simple unresolved cerebral contusion. I would again lay the strongest possible stress on the fact that these conditions can be set up by comparatively trivial-looking accidents, and that once established they are distressing and seriously disabling afflictions.

Treatment

The headache of unresolved cerebral contusion is fortunately sometimes preventable, and almost always curable. Prevention is possible chiefly in relation to the widespread but slight degrees of contusion associated with general deformation of the skull and concussion. It is to be attempted by the strict application of the old clinical maxim that every case of concussion must be treated by a definite period of rest in bed, and the very slow and cautious resumption of active life. The duration of such precautionary treatment may, to some extent, be regulated by the presumptive severity of the contusion in the given case. The best measures of this are the extent of the patient's loss of memory for the period of the accident, and the intensity of the so-called phenomena of reaction that have followed the concussion. Supposing headaches to have developed in spite of proper preventive treatment, they may be dealt with by another and lengthened period of rest in bed. This failing, a moderate decompressive opening in the skull and dura is practically certain of success. It should be made at the place of election low down in the right temporal fossa under the muscles. Localized contusion, as it has to be more intense to produce similar symptoms, is less amenable to precautionary treatment by rest, and is more likely to call for primary operative treatment. This consists in making an opening in the skull and dura over the contused region, so that the latter may be released from pressure, its normal circulation re-established and resolution occur. There are certain cases in which the occurrence of a serious amount of local cerebral contusion may be assumed to be present from the very

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PHYSICIANS SERVICE IN 1957

Report of the President, CHARLES J. ASHWORTH, M.D., at the Ninth Annual Meeting of the Corporation of the Rhode Island Medical Society Physicians Service on January 29, 1958

EVERY ANNUAL REPORT to a Corporation merits study, and this one together with those of other officers to be detailed immediately after these remarks, will reveal that after the usual close scrutiny of the data presented, your plan is succeeding in maintaining its objectives to the public.

You have left to your board of directors, made up as it is of twelve doctors and six laymen, the latter chosen with the utmost consideration of their varying abilities to further the best interests of this plan, guarding as they have done and continue to do, any imbalance, yet co-operating in every endeavor we have put forth, to make Physicians Service Plan one of the best in this entire country. It cannot be doubted that, as your documented report will show, over twenty-five hundred more subscribers indicates our appeal to more people and expresses confidence in our effort to produce something satisfactory to all interested segments of the public we serve.

A summary of enrollment trends for the year 1957 is as follows:

The gain of 482 Physicians Service Contracts for the year 1957 was by far the smallest of any year since the Plan was organized.

It is important, I think, to evaluate the reason for this small growth, as it may have some significance for the future.

	Contracts
258 new groups were secured covering.....	3,684
net gain on all other existing groups.....	4,824
Total Gains	<u>8,508</u>
70 Companies went out of business during year—loss	1,826
25 Companies had sizable reductions in employment—loss	3,832
9 Companies dropped Physicians Service and took commercial insurance.....	1,019
Total Loss on Direct Payment Contracts.....	1,349
Total Losses	<u>8,026</u>
Net gain for year (2,566 Subscribers) or	<u>482</u>

While we were fortunate to come up with any gain at all under present economic conditions in the state, it would appear that we are nearing the point from which enrollment gains will be difficult to maintain.

I am deliberately avoiding many figures which

will be given by your secretary and treasurer in order to dwell with more than the usual emphasis not upon our accomplishments in this year just ended, but rather upon the position of Physicians Service with direct relation to its future.

Any discussion of the future of Physicians Service must of necessity consider the past and present scope of this program in order that the entire structure may be viewed in its proper perspective. Under what considerations did the Society initiate its voluntary surgical plan? What did it intend to accomplish? Has it, and is it, accomplishing its original purposes? What current factors are affecting our concepts of providing low-cost prepaid voluntary insurance?

Original Objectives

The history of the development of our Physicians Service is recorded in the archives of the Society, and particularly in the reports of the House of Delegates as published in our own medical journal. We publicly and clearly stated our objectives from the beginning. It should be carefully noted that the Society started its prepaid insurance study in 1944, and drafted a program known as the *Rhode Island Plan*, utilizing private insurance companies, 1947, three years before Physicians Service came into being.

The pattern for *Physicians Service* was laid out in a program that stated these objectives:

- “(1) To increase the extent to which voluntary insurance against the cost of medical care is made available to the people of the State of Rhode Island;
- “(2) To increase the effectiveness of such insurance through the voluntary cooperation of its members;
- “(3) To make such insurance available at the lowest practicable cost under competitive conditions;
- “(4) To safeguard the physician-patient relationship deemed necessary by the Society to maintain and improve the high standards of medical care in the State of Rhode Island.”

These were basic. We did not seek to sell insurance coverage as a business. We sought to render

a service to the people of this state to aid them in meeting the costs of medical care. That we have rendered that service, and have fulfilled our objectives, few can deny.

The medical profession, believing that its voluntary effort should aid those in the lower income classifications, adopted the proposal that persons whose annual family income is under certain limits shall receive the service for the indemnity fee listed. Today nine hundred and fifteen participating physicians are still supporting that contribution—guaranteeing service for the indemnity listed—a contribution that no other community organization or group of individuals has matched in any manner.

In the fulfillment of this purpose for a low cost prepaid voluntary insurance program, aimed particularly to aid the low income group, we now find that plan criticized at times because we do not expand the program and extend the income limits. Is such criticism truly justified? I think not in the light of what we started out to do, and what we have done. We are not directly in the insurance business corporation, and therefore we seek no profits nor possessions for ourselves. Any assets, and reserves, that accrue to the Corporation are held in trust for the operation of the Plan, and as guaranteed protection to the subscribers. We can extend the program only in proportion to retaining premium income, and any increase of benefits that calls for an additional premium charge to the subscriber must be carefully evaluated and approved.

Today, due to labor-management wage agreements, hospitalization, surgical-medical, life, and allied insurance coverages are included in the bargaining and are often referred to as "fringe benefits." In view of this practice it is well that we consider its effect on Physicians Service. Of our 505,000 subscribers approximately 384,000 are enrolled through employed groups. Of these 384,000, approximately 298,000, or 61.6% have their membership paid entirely, or in major part, by industry.

Thus management offers the stated benefits of our current program as part of its wage agreement, and labor accepts it as a "fringe benefit." Any dissatisfaction, therefore, with the amount of insurance coverage should not be directed at us, the third party providing the professional services under clearly stated provisions.

If industry is prepared to support additional or extended coverage through wage contracts, Physicians Service, I am sure, can provide it at a reasonable cost, but not at the expense of its participating physicians.

As a non-profit medical service corporation Physicians Service is required by law that rates to subscribers be consistent with the best interests of the public, and shall "at all times be subject to the ap-

proval of the director of business regulation." We are required by law to file annual statements of operation, and the director of business regulation of Rhode Island audits our financial condition and our methods of doing business. Our reserve funds may be invested only in the same manner permitted by law for the investment of assets of savings banks of this State.

Any critic, therefore, would do well to realize that we operate under strict supervision of the regulatory laws imposed on all other business corporations, that we render a community service without a profit motive, and that we are not a private insurance company. We may attempt wider coverage only with the approval of the insurance commissioner, and only if it is actuarially sound, and in the best public interest.

Improvements Continually Sought

One year ago, I reminded you that a committee, originally appointed by my predecessor, Doctor Joseph C. O'Connell, in the late months of 1954, was diligently engaged in the task of evolving a contract that would not only improve benefits to our subscribers, but would correspondingly equate the physician's recompense for such liberalization. This effort while inestimably costly in personal sacrifice by both the medical and lay members of your Board of Directors, was concerned not only with bringing your plan out of the obscurity that our neighboring state plans has submerged us, but with the realization that economic demands on the part of the public, often expressed by interests not sympathetic to medicine, nevertheless, constrains us to tailor any improvements in the plan to a pattern aimed at mutual satisfaction, an objective almost impossible of attainment.

May I emphasize for you as individuals, and as a profession, hardly one of us envisioned this trend in prepaid medical care insurance, when more than ten years ago we made certain commitments to aid the low income group in defraying the then rising costs of medical care, as a genuine gesture of sacrifice, against any federal legislation that would interfere with, or take over the control of private medical practice. The fact remains, however, that medical care as it is provided by doctors of medicine, in this present trend, has been swept into a maelstrom of economic edicts, and we are faced with a problem that calls for the utmost in realism and objectivity. May I add that we are not in any sense unmindful of the problems of the aged, and the chronically ill, and have included coverage for these members of our society in an expanded plan of extended medical coverage.

Consideration, therefore, of any new contract is going to make this a year of decision for medicine in Rhode Island. You the duly chosen representa-

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THE MEDICAL LIBRARY AT RHODE ISLAND HOSPITAL

Concepts as to the Relation of the Medical Library to Patient Care and To the Educational Program of the Teaching, Non-University Hospital

DORIS E. JOHNSON, B.A., B.S.

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Education never ends, is a saying that has always been true for the medical profession, but never more so than it is today. In our rapidly changing world where modern research is opening new doors and making new discoveries, even concepts once accepted as valid are being questioned and revised, sometimes over night. The very best therapy of today may be discarded tomorrow. How can a busy doctor hope to keep up with all this, with a minimum expenditure of time and effort? Medical meetings, clinics, conferences, lectures; all these are important and time-consuming, yet they cannot supply the diversified information that may be needed at a moment's notice. The doctor treating sick patients (especially if these patients are hospitalized) must have access to a good medical library, and this should be located where he may use it frequently without having to make special trips away from his work. Since disease in its many manifestations may be observed and studied best in a hospital, the library should be available there also, not only as a convenience to the practicing medical staff, but especially for the interns and residents who are often "on call," but not on duty in a ward or unit, unless needed.

The concept of locating medical libraries in hospitals is now so widely accepted that the Joint Commission on Accreditation of Hospitals, representing the American Medical Association, the American College of Surgeons, the American Hospital Association and the American College of Physicians, has set up standards for such libraries, and these must be met, if a hospital is to be accredited. Perhaps a quotation from the Ford Foundation's new brochure, *THE DIFFERENCE IT MAKES*, expresses the basic reason for this standardization most clearly, "Ultimately, the quality of medical care depends upon the skill, training and character of those who administer it... Getting his M.D. degree is only the beginning of a doctor's education, and most of his postgraduate work is centered in the hospital." We might add that while clinical experience is gained from direct contact

with patients, the evaluation, comparison of therapies, and knowledge of new advances must also come from a study of the recorded experiences and impressions of others. Assembling this material for reference is the library's main function; making it available is the librarian's job. In a "teaching, non-university" hospital and growing medical center such as ours, the library is, and must be, at the very heart of the educational program, and it makes an indirect, but very real contribution to the quality of patient care.

But the men of vision who founded our hospital had no need of standards to convince them of the importance of a medical library. The earliest plans show that ample provision had been made for one, and when the hospital first opened in 1868, more than a thousand volumes had already been collected. In such a survey, we cannot take time to describe this library in detail, but we may be very proud that it existed. Our traditions at Rhode Island Hospital are a precious heritage, and the medical center that we are building today is but the flowering of ideals of community service that are deeply rooted in our past.

If a hospital medical library is to function at its highest level, there are five basic requirements which must be met. Without any one of these, the library fails.

1. An administration convinced of the need for a good working library and willing to allow a liberal budget for its establishment and upkeep. (In some hospitals, the medical staff helps to support the library.)
2. A good location, with adequate space and good physical equipment.
3. An up-to-date and comprehensive collection of basic texts and journals. (Set forth in the standards referred to earlier in this paper.)
4. A librarian to receive and catalogue the literature. This person takes responsibility for keeping the collection intact and orders new books and journals within the means allowed by the budget. In teaching hospitals and institutions devoted to research, the librarian assembles material for various conferences, journal clubs, clinics, special projects, and for individual doctors. Her value to the medical

- staff is in direct proportion to the training she has had.
5. Cooperation of interns, residents and all who use the library by respecting the rights of others and by keeping whatever rules may be necessary. It is obvious that loss or mutilation of material can quickly deplete the most carefully stocked collection. Again, if the library is seldom used, the time, effort and money put into it are wasted. But systematic and intelligent recourse to the best in the literature can be very rewarding to all the medical staff and should be encouraged, if they would grow in knowledge and professional skill.

With these requisites in mind, it is the purpose of this paper to describe our medical library at Rhode Island Hospital, its main functions, its relation to patient care, and our concepts of what the medical library should contribute to the educational program of the teaching, non-university hospital.

Administration

Too often people tend to forget that no department can run efficiently without the support of an adequate budget. In these days of inflationary costs and careful analysis of the use of the patient's dollar, all expenditures have to be justified. We are very fortunate at Rhode Island Hospital that, just as our first trustees believed in the necessity for a good medical library, our present administration also follows in this tradition. Without their support, we could not possibly render the services so essential to a growing medical center. Our hospital, like all others, has its financial problems, but the curtailment of education is not looked upon as an economy. Any request for needed improvement or expansion has always received sympathetic consideration, and no expenditure deemed necessary by the librarian has ever been denied. This should be remembered and credit given when favorable comments or appreciation are expressed for library services.

Library Committee

The Library Committee was not included among the basic requisites for good service, because their functions vary so widely in different hospitals. Primarily, this group is composed of members of the medical staff, and the part that they play in library administration depends upon a number of varying factors. In some hospitals, they are very active in library affairs; in others, their role is nominal. They may meet frequently to discuss problems and help in the selection of books; or they may meet only when occasional difficulties arise. They may have control of the budget, or act only in an advisory capacity. They may serve as a liaison between the administration and the librarian, or between the administration and the doctors.

Sometimes they are instrumental in raising needed funds for library expenditures. But there is one respect in which the Library Committee can become essential. If it is composed of doctors who are highly regarded or popular members of the medical staff, their help in dealing with any problems relating to the house officers, their support in initiating any program of service can be of great benefit to the librarian. The influence of such a Committee cannot be underestimated, especially with regard to the younger men. It might be important to keep that in mind when help is needed in the enforcement or interpretation of library rules.

Here at Rhode Island Hospital, where our doctors are already engaged in an exacting program, the Library Committee meets only when special problems arise, and then at the request of the librarian. Since our administration assumes financial responsibility for services and upkeep, while the librarian takes care of the details of management, the Library Committee is concerned mainly with general policies, regulations or rules, with suggestions as to equipment, and with the presentation of requests to the staff association for aid in special projects. Individual members of the Committee are always available for consultation, and the infrequency of formal meetings is not due to lack of interest, but to lack of need for them. Of course, in a hospital where the administration could not bear the entire cost of the library, or where the librarian was untrained or working on a part-time basis, the functions and responsibilities of the Library Committee would of necessity be quite different.

Location

We are unusually fortunate in our location. Since 1931, the library has been established in Peters House, the doctors' residence, where it now occupies a considerable portion of the main floor. Wide windows and high ceilings give light and spaciousness, while a large Oriental rug, deep easy chairs, soft lighting and beautiful wall paneling create an atmosphere of opulence and comfort. It is not only a delightful place in which to read or study, but a restful retreat from the tension of hospital wards. No page system sounds here, and one may read, concentrate (or even nap a little) in peace. We owe all this to the generous donors who built Peters House, not to be a dormitory, but a home for the interns and residents, as well as a kind of gentlemen's club for the medical staff. As a result, we have inherited a rare combination of the leisurely and the practical—and much research is really accomplished, even though the pursuit of knowledge sometimes falters under the spell of Morpheus. We frankly admit that advocates of strict utilitarian standards might frown upon this, and occasionally we do hear mild complaints that our chairs are "too comfortable." However, no one

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has volunteered to do anything about it, and we think it would take a brave librarian even to suggest a change.

Atmosphere

Although reasonable quiet is maintained, the atmosphere is generally informal. Conversation is allowed, provided no one is disturbed, and occasionally the library has become the scene of a lively and enjoyable discussion. The young doctors like to catch their chiefs of staff in a moment of relaxation to ask leading questions. However, if a debate gets too animated or out-of-hand, the participants are immediately invited to repair to a nearby conference room. Our reason for mentioning this is to show that our library is much more to us than a place where books are kept. Through the years, it has also become a friendly center where ideas and experiences may be shared; where the old and the new rub elbows with each other; a place where the youngest intern as well as the retired physician may feel at home.

Book Collection

It is our belief that if a hospital library is to be up to date and of service to the medical staff, its entire collection of textbooks must be renewed at least once every five years. Medical treatment, surgical techniques, and even concepts that are more than five years old are frequently changing, sometimes obsolete. This, of course, means quite an expenditure of money, yet a library that does not keep up with modern times can contribute little to a teaching program. The American Medical Association, the American College of Surgeons, and the Medical Library Association have each published a list of basic texts and journals recommended for hospital medical libraries. Our policy has been to use these lists as guides, and to have available the latest editions of many of the books chosen in general fields and in each specialty. We also have arranged to have new books sent to us on approval. From these, we purchase the ones selected by our chiefs of staff and our residents, in accordance with our means. Altogether, we have approximately three thousand volumes, six hundred of which are recent texts; about four hundred are older books and monographs—these gradually get weeded out, unless they have some historic value—and the rest are bound volumes of medical journals. The original library, founded in 1868, has long since been dispersed, most of those early books having been transferred to the archives of the Rhode Island Medical Society, or to private collections as items of rare value. In general, our concept is that lack of space and proper protective measures do not allow a hospital library to keep rare books or "collector's items," no matter how much we may appreciate them. A hospital's needs

are primarily utilitarian and practical. Again, our proximity to the excellent libraries of Brown University, the Rhode Island Medical Society, as well as to several outstanding collections in Boston, make it easy for us to borrow most medical texts or journals that we might want.

Service Copies for Interns

In addition to the textbooks mentioned above, we have also initiated a program of purchasing duplicate copies of some special titles (selected by the chiefs on each service) to lend to interns who are on rotation through the various specialties. This has proved very helpful to the interns, and also has the advantage of making it less likely that the original copy, kept in the library for reference, will disappear. (More about this problem later.) We think that it is cheaper to buy two copies of these special texts and have them both available, than to buy one, lose it, and replace it by another copy. Altogether, we have only ten of these titles (though we plan to add to the list) and we do not try to cover medicine or surgery in this way. The main purpose of this program is to provide texts in the smaller specialties where the intern needs to have such books available for study, but would not want to buy them, since he may not continue to work in that field.

Small Departmental Collections

Some departments that have special funds of their own—memorial funds, gifts, etc.—are also providing small collections of basic texts for the use of doctors serving on their units. These are ordered through the librarian, who catalogues them in order that the location of each volume may be recorded in the library. Such collections are very helpful, for they provide ready reference to the literature during rounds or at daily conferences. We think that books purchased for departmental use are good to have, provided that sufficient care is taken that they do not get lost. However, we still believe that the library should also have copies of most basic texts, because doctors engaged in general research would find it very difficult to go from one special collection to another. Medicine cannot be so sharply divided into specialties that there will be no overlapping; therefore, if books were scattered all over the hospital, it is obvious that consulting them would be a wearisome task. Whenever there must be a choice between having a book in a department or in a central library, we believe that the library should be the place selected. The only exceptions to this would be texts so very technical or specialized that they could only be used by a limited number of trained people.

Medical Journals

Since medicine is changing so rapidly that textbooks are often out of date as soon as they are

printed, the greater portion of our budget goes toward providing current medical journals, year-books, loose-leaf systems and abstract services. Using the before-mentioned lists as guides, we have selected many of the journals recommended in each field, as well as others that our chiefs of staff want. Our library now receives one hundred and thirty-four journals a month, one hundred of which we purchase, while the others are gifts; either from our doctors, from local medical societies, or come to us free-of-charge. European medicine is represented mainly by journals from the British Isles and the Scandinavian countries, with one from France and one (in translation) from West Germany. Also, we have a trial subscription to an abstract service (in English) of literature in the basic sciences and clinical medicine from the Soviet Union. Because of our interest in rare pathology, we receive the SOUTH AFRICAN MEDICAL JOURNAL, as well as the AUSTRALASIAN ANNALS OF MEDICINE. Gifts of journals (in English) from Japan and from the Hawaiian Islands make up our holdings from the Far East and the Pacific.

Gift Subscriptions

Speaking of gifts, although we are grateful to any physician who wishes to bring us his copies of a journal, we have found that it is better not to depend upon this source, if the journal is one that we need. In such cases, we prefer that the subscription should be sent to us direct (if the doctor really wishes to make us a gift). If he wants to share his own copies, we will gladly accept them as duplicates. Experience has shown that depending upon doctors to remember to bring in journals when they have finished reading them is usually most unsatisfactory. But, of course, for special items that we might not otherwise see, or for journals not in much demand, receiving them in this way is better than not getting them at all.

Ephemeral Material and Reprints

Finally, there is also the vast quantity of ephemeral material that comes in the mail—brochures from the drug houses, bulletins from many sources, pamphlets, and advertising matter *ad infinitum*. Most of this is kept for a short time only. The same is true of many reprints, except papers by members of our own staff. These are in process of being re-catalogued. We plan to keep them in folders under the name of each doctor, for we feel that the interest in them here will be primarily because of the author, rather than the subject discussed. In general, we do not keep reprints when we have the journal in which an article appeared (except in the case of our own doctors, as mentioned), but we do send away for articles that are not included in our journals. Photostat copies are also made of some of the literature that we borrow through inter-

library loan. Some departments are building up their own collections of reprints, which are catalogued under the supervision of the librarian, but we have not felt the need for such a collection in the library.

Back Files of Journals

The decision as to how many volumes of each medical journal should be kept is a troublesome one which each hospital library must solve in its own way. Limited storage space makes it necessary for many libraries to limit their holdings to an arbitrary number of years—usually five or ten—after which time older volumes are sent to some central place for storage, given to another library, or sold to secondhand dealers. Because there is so much interest here in clinical research, classic references of the past are constantly consulted, which means that we must keep our journals for quite a number of years. We may be compelled to set a limit upon our holdings at some future time when our storage space becomes filled, but we will probably always need to keep a file of at least fifteen or twenty years of the basic journals. As yet, microfilm copies have not been seriously thought of, but it is quite possible that they may be considered at some time in the future. Meanwhile, we bind most of the material that we keep.

Special Index

One feature of our library of which we are very proud is a special index or card file of ready references that we have been keeping for ten years now. Here are listed bibliographies, papers, and references that have been recommended by doctors as helpful, and it is supplemented by some of the worthwhile or timely articles that appear in the current literature. Like Topsy, it has seemed to grow almost by itself, but we keep it from getting unwieldy by weeding out material that has been superseded by later references. Our aim is to have two or three "key" articles with bibliographies on any given topic, as well as rare cases that cannot readily be found from the textbooks. Busy clinicians who do not like to pore over the indexes are glad to have such a list available; others use it as a starting point for further reading. If the librarian is not on duty, or is busily engaged with another problem, the answers to questions may often be found by consulting this file. Again and again, it has proved to be a time saver, and by now we could hardly do without it. Once a bibliography has been prepared, once a list of references has been set aside, and especially when some obscure paper has at long last been located, why not keep a record of it, instead of having to repeat the process at some future time for other doctors? We believe that the time taken in making such a list is well spent. It is much less than the hours that might be lost in tracking down some paper that is only vaguely remembered. Keep-

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ANNUAL REPEAT TEST FOR UTERINE CANCER CYTOLOGY

THE RHODE ISLAND State Cancer Cytology Program was established as a pilot project to determine the value of cytology in the early detection of cancer on a mass screening basis. During the first year of operation (December, 1956 to December, 1957) approximately 17,000 women were screened and approximately 1% were found to have unsuspected uterine cancer, predominantly carcinoma-in-situ of cervix.

The second phase of the program is to re-examine at yearly intervals, for at least three years, all women who have participated in this screening project. The main purpose of this retesting is to evaluate the accuracy of the smear test in uterine cancer detection, as well as to detect new cases which may have developed since the previous examination.

Retesting will ultimately provide valuable information as to the time period for development of uterine cancer and how often repeat smear tests should be taken.

It should be emphasized that in this program, a report of "atypical" does not necessarily indicate the presence of malignant cells and does not warrant a cone biopsy. It indicates an abnormality of cells which are probably due to benign inflammatory conditions such as trichomonas infection, severe endocervicitis, pregnancy changes, or post-partum changes.

To insure the accuracy of this cytology screening

technique, all atypical cases should be re-examined by repeating the test in one, three, or six months depending upon the degree of abnormality. The results up to now have shown an extremely small number of atypical smears developing into actual positive cases. In most cases the cytology became negative after proper treatment for various benign conditions.

The final answer and measure of success of this cytology screening survey will be determined by continuation of the study and repeated cytologic tests annually. It is hoped that the doctors of this state will continue their excellent cooperation by submitting repeat smears on women who were examined one year ago. Reminder post cards will be sent to the doctor in each case.

NATIONAL LIBRARY WEEK

Many of us may be surprised to learn that Americans, as a nation, have not formed the habit of reading. A Gallup Poll of 1955 showed that 61% of the adults in America had read no book, except the Bible, in the previous year. Another survey disclosed that half the nation's adults live within a mile of a public library, but only 1/5 of them go inside. This is bad enough, but what shall we say of a young woman, a college graduate, who for five years lived in New York directly across the street from the great Morgan Library, and said smilingly, that she never had time to enter that treasure house.

It is to help these unfortunates that National Library Week—March 16-22, 1958—sponsored by the National Book Committee, has come into being. Its purpose is to encourage the people of the United States to do more reading, and its theme for the first year is "Wake Up and Read!" for we cannot afford a country of lazy minds whose boredom comes of knowing little and caring less; nor can we afford to become a nation of people bombinating in the void of radio and television.

As for Rhode Island, National Library Week should be welcome indeed, for we are rich in libraries, some internationally famous, and not the least of them our Rhode Island Medical Library. Fifty years ago it left the Providence Public Library where it was dying of inanition and came to its present home. With it, and almost literally bringing it, came our loyal, efficient Miss Grace Dickerman, whom the years have touched so very lightly. Later on came Mrs. Helen DeJong, as quick in mind as she is in body. If you find the Library a pleasant place in which to read you will surely credit some of your pleasure to the friendly helpfulness of our librarians.

If you chance to be an old-time frequenter of the library, it is heartening to see how things have changed as to the number of those who avail themselves of its services. Not many years ago, one might spend hours there, alone or almost alone. Now it is a busy mart for the book man; a real rendezvous for the students from the nearby schools and colleges, so that not one week only, but every week is Library Week.

In his Annual Address of September 6, 1900, Doctor George G. Hersey remarked, "The library of this Society is the fruit of an early planting for at the first election of officers in 1812 the Society chose a librarian. It is not probable that he had a hard time caring for books as he made no annual report and asked for no appropriation, as the office involved no duties it was finally discontinued. The original idea was, however, reborn in 1835, when Doctor Caleb Fiske, who subsequently formed the Fiske Prize Fund, gave to the Society a collection of valuable books." It was from this modest beginning that our library has grown to the proportions of which we are so justly proud.

RHODE ISLAND SOCIETY OF PATHOLOGISTS

It may not be known to many that there exists in this state a small but active society of pathologists, which was organized nine years ago. It is composed of physicians who are practicing pathology exclusively. Most of them are duly certified by the American Board of Pathology and play a vital role in the health and welfare of the population of the state. The Society meets every other month, with each of

the hospitals in the greater Providence area serving as host on a rotating basis. These meetings comprise a scientific, as well as business session. Once a year there is a joint meeting with the Laboratory Club of Rhode Island at which time varied scientific papers are presented.

The purposes of the Society are manifold. It fosters a spirit of cooperation among pathologists of the state to improve the practice of pathology. It serves as a communication center, with regard to both scientific and organizational matters. It plays an active role in the recruitment of technologists and laboratory aides.

The Society at present is concerned with several problems vital to the future of pathology and to medicine as a whole. One of these is the role of the private laboratory without the supervision of a pathologist. Another is the development of insurance programs (including Physicians Service and Medicare) which provide for indiscriminate laboratory coverage without carefully delineating the type of laboratory to be used.

The Rhode Island Society of Pathologists is anxious to further the best interests of medicine. This can be done only if pathologists are given full recognition as practicing physicians. During these unsettled times, with the ominous threat of socialization of medicine, it behooves all of us to be acquainted with the problems of our colleagues in the field of pathology.

BASIC OBJECTIVES

With the Rhode Island Medical Society Physicians Service now ranked as number one plan of its kind in the nation on the basis of its enrollment of the eligible population, and on the basis of its excellent coverage at the lowest operating cost of any such program, it is timely that we review its progress annually.

In his annual report as president of the Physicians Service Corporation, published on page 140, in this issue of the Journal, Doctor Charles Ashworth has fittingly restated the basic objectives sought when the Society undertook its study for a prepaid voluntary surgical plan back in 1944 which culminated with the Rhode Island Plan in 1947, and Physicians Service three years later.

As Doctor Ashworth has noted well—"We did not seek to sell insurance coverage as a business. We sought to render a service to the people to aid them in meeting the costs of medical care . . . and the medical profession, believing that its voluntary effort should aid those in the lower income classifications, adopted the proposal that persons whose annual family income is under certain limits shall receive the service for the indemnity fee listed. Today nine hundred and fifteen participating physicians are still supporting that contribution —

concluded on next page

guaranteeing service for the indemnity listed—a contribution that no other community organization or group of individuals has matched in any manner."

The inflationary era in which we live prompts many demands, often excessive and unwarranted, upon stable programs that seek to maintain a guaranteed service to specified groups. Physicians Service will undoubtedly be subjected to such pressures, but we are strong in our belief that our basic objectives must be upheld. The problem of the lower income group will always be with us, and the expressed decision of the medical profession throughout this state to guarantee aid to those groups first, must not be destroyed by those who would exploit the service feature of the Plan to encompass larger segments of the population at the expense of the participating doctors.

If industry, as Doctor Ashworth noted in his report, is prepared to support additional or extended coverage through wage contracts, Physicians Service can provide it at a reasonable cost. But any expansion of coverage should be on an indemnity basis in fairness to all subscribers, as well as to the participating physicians who have from the beginning protected the interests of the low income group, and at the same time agreed that if the Plan could not at any time pay the benefits a reduced payment would be accepted.

PHYSICIANS SERVICE IN 1957

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tives of some eight hundred doctors of this state, have thrust upon you, a duty and responsibility of making a decision not only with due respect to the best interests of this community, but also with respect to the noble effort to which you are dedicated by tradition.

It is my sincere hope that you will be appreciative of the untold hours of labor that have gone into not only this project of a new contract and extended coverage, but the entire operation of your plan, time given generously by doctors and layman alike, and with due, impartial consideration to all. Condition, therefore, your considerations and deliberations to the end that whether you believe it or not, these proposals are brought to you with the basic and best interests of the medical profession in mind and, cushioned against any adverse or subversive factor that would tend to lower our standards of medical dignity, to what I will call an unprofessional level.

Outstanding in the Nation

I am confident that you would hold me remiss, were I not at this time to express for you a word of gratitude to your committees, your directors, and to the Executive Director, Mr. Saunders, his asso-

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ciate and administrative staff for their labors in bringing about any accomplishment or success in the year just ended:

- (1) Largest percentage of population enrolled in country—63.5% against Delaware with 62.5%;
- (2) Lowest operating cost of any plan—5.1%;

Let me leave you with this thought quoted from Stefan Hansen, an outstanding authority in the insurance industry who uttered it only a little more than one year ago, and whose envisionment of the problems with which we are all concerned is most applicable to our present task.

"Like any evolution, that of voluntary medical care insurance has not been without self-interest and sacrifice, hope and disappointment, blind alleys and open roads, or without severe stresses and strains. But it is the peculiar merit of the voluntary approach that problems can be localized and resolved by discussion and agreement."

ON CERTAIN MINOR INJURIES OF THE BRAIN

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nature of the injury. Such an injury, for example, is a glancing blow by a rifle bullet. Here, though the skull seems to be intact, and even the scalp is only grazed, cerebral contusion may be assumed to be present, and operation advised, even in the absence of symptoms.

We have now reviewed a limited but very definite and compact section of the great subject of head injuries. This review has, I hope, illustrated to some extent an important branch of cerebral pathology—the functional relations of the skull and brain—and at the same time remained in close contact with the practical realities of medical work.

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Blocks Parasympathetic Hyperactivity, thus Encouraging Mucosal Regeneration in Peptic Ulcer

Whenever it is necessary to alleviate peptic ulcer pain and to control associated gastric hyperacidity and hypermotility, Pro-Banthīne is the anticholinergic chosen by a high percentage of physicians throughout the United States and Canada.

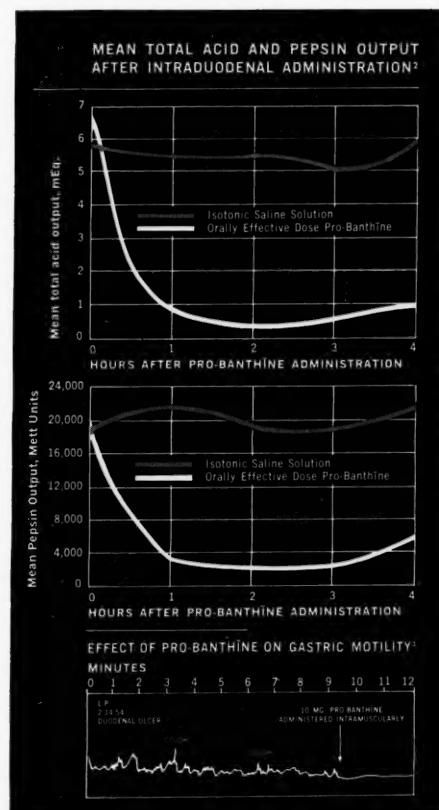
Pro-Banthīne is preferred because it rapidly relieves pain and hastens healing with minimal side reactions.

Barowsky¹ reflects a large segment of professional opinion when he states:

"We prefer to use Pro-Banthīne because we have had greater and more satisfactory experience with it. Our experimental and clinical studies with the drug have demonstrated many advantages. Apparently, not all the anticholinergic drugs affect all the organs innervated by the parasympathetic to the same degree. Whereas, more extensive side-effects have been encountered with relatively smaller amounts of other drugs, fewer patients experienced innocuous side reactions with massive doses of Pro-Banthīne."

The initial dosage is one 15-mg. tablet with meals and two tablets at bedtime. For severe manifestations two or more tablets four times daily may be prescribed. Pro-Banthīne is supplied in 15-mg. sugar-coated tablets.

G. D. Searle & Co., Chicago 80, Ill.
Research in the Service of Medicine.



1. Barowsky, H., in discussion of Barowsky, H.; Schwartz, S. A., and Lister, J.: Experience with Short-Term Intensive Anticholinergic Therapy of Peptic Ulcer, Am. J. Gastroenterol. 27:156 (Feb.) 1957.
2. Sun, D. C. H., and Shay, H.: Optimal Effective Dose of Anticholinergic Drugs in Peptic Ulcer Therapy, Arch. Int. Med. 97:442 (April) 1956.
3. Lichtenstein, J.; Morehouse, M. G., and Osmon, K. L.: Pro-Banthine in the Treatment of Peptic Ulcer, Am. J. M. Sc. 232:156 (Aug.) 1956.

DISTRICT MEDICAL SOCIETY MEETINGS

PROVIDENCE MEDICAL ASSOCIATION

The 11th Annual Meeting of the Providence Medical Association was held at the Rhode Island Medical Society library on Monday, January 6, 1958. The meeting was called to order by the president, Doctor Thomas L. Greason, at 8:30 P.M.

Minutes of Previous Meeting

The president asked if there was a request for the reading of the minutes of the previous meeting. There was none.

Annual Report of the Secretary

Doctor Michael DiMaio, secretary of the Association, read his annual report for the year 1957, a copy of which is made part of the official records of the meeting. It was moved, seconded, and passed that the report be received and placed on file.

Annual Report of the Treasurer

Doctor Frank I. Matteo, treasurer, presented his annual report which had been approved by the Executive Committee. It was moved, seconded, and passed that the report be received, approved, and placed on file.

Annual Address of the President

Doctor Thomas L. Greason, president, presented his annual address on the subject of *Observations—Rhode Island Blue Cross and Physicians Service* in which he reviewed the history of the program and criticized its inadequacy as regards benefits for medical and mental illnesses. The address is made part of the official minutes of the meeting.

Election of Officers for 1958

Doctor DiMaio, secretary, reported that he had received no counter-nominations to the slate of officers nominated by the Executive Committee to serve the Association in 1958. He therefore moved the election of the slate as submitted to the membership with the notice of the December meeting.

Action: It was moved, seconded, and unanimously passed that the slate of officers nominated by the Executive Committee be declared elected to serve until the next Annual Meeting of the Association.

The slate is listed as follows:

Nomination of Officers for 1958

<i>President</i>	JOSEPH G. McWILLIAMS, M.D.
<i>Vice-President</i>	JOHN C. HAM, M.D.
<i>Secretary</i>	MICHAEL DiMAIO, M.D.
<i>Treasurer</i>	FRANK I. MATTEO, M.D.
<i>Trustee of Medical Library (1 year)</i>	FRANCESCO RONCHESE, M.D.

Executive Committee (3 year terms)

ROBERT V. LEWIS, M.D.
ARNOLD PORTER, M.D.

House of Delegates: Charles J. Ashworth, M.D.; Irving A. Beck, M.D.; Alex M. Burgess, Jr., M.D.; Bertram Buxton, Jr., M.D.; Wilfred I. Carney, M.D.; Francis H. Chafee, M.D.; William B. Cohen, M.D.; Harry E. Darrah, M.D.; Michael DiMaio, M.D.; William J. H. Fischer, Jr., M.D.; Frank D. Fratantuono, M.D.; J. Merrill Gibson, M.D.; John F. W. Gilman, M.D.; Seebert J. Goldowsky, M.D.; Stanley Grzebien, M.D.; John C. Ham, M.D.; Joseph A. Hindle, M.D.; Albert H. Jackvony, M.D.; Walter S. Jones, M.D.; Ernest K. Landsteiner, M.D.; Joseph G. McWilliams, M.D.; William S. Nerone, M.D.; Francis W. Nevitt, M.D.; Rudolph W. Pearson, M.D.; Arnold Porter, M.D.; William A. Reid, M.D.; Louis A. Sage, M.D.; William J. Schwab, M.D.; James J. Sheridan, M.D.; Stanley D. Simon, M.D.

Induction of New President

Doctor Greason appointed Doctors Daniel Young and Donald DeNyse to escort Doctor Joseph G. McWilliams, the new president, to the rostrum.

Doctor McWilliams briefly expressed his appreciation to the membership for the honor accorded him and he asked for continued support from every member during the coming year. He also announced that he would notify members of their appointment to committees within the week. At the conclusion of his remarks Doctor McWilliams, in behalf of the Association, presented an engraved gavel to Doctor Greason, the retiring president.

Doctor Greason thanked the Association for its support during 1957 and for the gavel memento presented to him.

Other officers elected were called upon to stand and be recognized by the membership.

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MILK COMMISSION REPORT — PROVIDENCE MEDICAL ASSOCIATION, 1957

CERTIFIED MILK in Providence during 1957 was obtained from the following farms: Cherry Hill Farm, North Beverly, Mass.; Hampshire Hills Farm, Wilton, N. H.; Hillside Farm, Cranston, R. I.

Through the courtesy and cooperation of the Boston Commission we have accepted their certification of one farm from Massachusetts and one from New Hampshire.

Bacteriological and chemical examinations of certified milk are made in the laboratories of Brown University under the supervision of Professor Charles Stuart. During the past year approximately 315 samples have been tested and we had no bacteria counts above the legal standard among this group.

All of the herds are under State and Federal supervision and are free from Tuberculosis and *Brucella abortus* infections.

The Commission, four years ago, discontinued the sale of Raw Certified Milk in the Providence market to conform with the standards in most of the larger cities. The legal standard for Pasteurized Certified milk is still 500 colonies per ml. and the actual count on all samples examined by this Commission the past year was 58 colonies per ml. The prepasteurized count on this milk must be under 10,000 and actual count was 1130 colonies per ml.

Vitamin D Certified Milk is defined as whole Certified Milk rendered antirachitic by irradiation or by the addition of a concentrate and shall be of sufficient vitamin potency to show, by biological assay, a content of at least 400 U.S.P. units per quart.

The Wisconsin Alumni Research Foundation of Madison, Wisconsin, is doing the assaying of Vita-

min D from Hillside Farm and the results have been entirely satisfactory. Two tests per year are required by this Commission.

Certified Fat-free (Skim) Milk, containing not more than 0.05 per cent butter fat, and with Vitamin A added has conformed to the standards set by the American Association of Medical Milk Commissions.

For thirty-one years the samples of Certified Milk have been analyzed in the Bacteriology Department of Brown University under the expert guidance of Professor Charles Stuart. Due to unforeseen circumstances it has been necessary to terminate this community service. On November 5, 1957, the secretary of the Milk Commission wrote the following to Professor J. Walter Wilson, of Brown University, "It was voted that the secretary convey to Brown University the sincere thanks of the Milk Commission for the many years of service rendered this committee by the unselfish and cooperative work performed by Professor Stuart."

Commencing November 11 the analysis of milk samples will be performed by the Rhode Island Quality Milk Association under the supervision of Doctor Richard Parry.

FRANK I. MATTEO, M.D., *Chairman*

JOHN T. BARRETT, M.D.

D. WILLIAM BELL, M.D.

GEORGE E. BOWLES, M.D.

BERTRAM H. BUXTON, JR., M.D.

HAROLD G. CALDER, M.D.

JOHN E. FARLEY, JR., M.D.

JOHN P. GRADY, M.D.

HENRY E. UTTER, M.D.

REUBEN C. BATES, M.D., *Secretary*

MONTHLY AVERAGES OF CERTIFIED MILK FOR 1957

	CHERRY HILL H. P. HOOD			HAMPSHIRE HILLS			HILLSIDE FARM								
	Pasteurized			Pasteurized			Pasteurized			Skimmed with Vit. A & D			Raw		
	B.F.	T.S.	C.C.	B.F.	T.S.	C.C.	B.F.	T.S.	C.C.	Bacteria per C.C.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	
January	4.0	12.32	4	4.2	12.77	767	3.9	12.42	2	0.1	8.2	2	4.1	12.57	1130
February	4.0	12.32	4	4.2	12.72	213	3.9	12.25	5	0.1	8.3	5			
March	3.9	12.28	2	4.2	12.71	237	3.9	12.19	2	0.1	8.0	3			
April	3.9	12.17	2	4.2	12.62	66	4.0	12.42	2	0.1	8.2	78			
May	3.9	12.27	3	4.1	12.49	83	4.1	12.39	18	0.1	8.2	25			
June	4.0	12.37	3	4.1	12.71	54	4.1	12.45	70	0.1	8.1	133			
July	3.9	12.26	5	4.0	12.30	69	4.0	12.29	82	0.1	8.1	39			
August	3.9	12.11	13	3.9	12.15	72	3.8	12.04	138	0.1	8.1	177			
September	4.0	12.21	5	4.1	12.65	53	3.8	11.99	10	0.1	8.2	102			
October	4.0	12.39	27	3.9	12.29	61	4.0	12.15	11	0.1	8.1	15			
November	4.0	12.90	7	4.8	13.69	10	3.9	12.40	37	.08	8.6	25			
December	3.9	12.74	8	4.3	13.62	7	4.0	12.54	7	0.6	8.6	8			
Yearly Average	3.9	12.36	7	4.2	12.72	141	3.9	12.29	32	0.1	8.2	51	4.1	12.57	1130

DISTRICT MEDICAL SOCIETY MEETINGS
concluded from page 150

Report of the Executive Committee

Doctor DiMaio reported the Executive Committee had approved of the applications for active membership of the following physicians and it recommends their election by the Association: David M. Barry, M.D.; J. Merrill Gibson, Jr., M.D., and Richard E. Noon, M.D.

It was moved, seconded, and unanimously adopted that the applicants be elected to active membership.

Award of Membership Certificates

Doctor Greason awarded certificates of membership to those physicians elected by the Association at its December meeting.

Scientific Program

The president called upon Doctor Beck to give a review of the scientific film to be presented. Doctor Beck briefly discussed the medical motion picture *William Harvey and the Circulation of the Blood*, which the program committee had voted to present in recognition of the anniversary year of Doctor Harvey's death.

Adjournment

At the conclusion of the showing of the film the

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meeting was declared adjourned at 10:15 P.M.

Attendance was 86.

Collation was served.

Respectfully submitted,
 MICHAEL DiMAIO, M.D., *Secretary*

NEWPORT COUNTY MEDICAL SOCIETY

The January meeting of the Newport County Medical Society was held at the Hotel Viking on January 29, 1958, at 8:00 P.M. Dr. Malone presided. The speaker of the evening was Mr. Victor Pedrella, a well-known accountant, who gave a very interesting discussion of tax problems which was followed by a lively question and answer period.

The minutes of the last meeting were read and approved. Dr. Malone reported for the last meeting of the Council which he attended for Dr. Adelson and discussed the meeting which had taken place in Georgia regarding Medicare.

The application of Dr. Henry L. Giard of Portsmouth was returned from the Censors with approval. Following a motion by Dr. Ciarla and a second by Dr. Bestoso, Dr. Giard was accepted for membership in the Society. The application of Dr. Theodore E. Schuur of Portsmouth was sent to the censors for consideration.

Dr. Fletcher stated that when meetings are scheduled on the last Wednesday of the month it is almost impossible to avoid conflict with the meetings of the House of Delegates and suggested that the new secretary schedule meetings either the first or if necessary the second Wednesday of the month. The Society gave approval to this.

Election of new officers took place and the following were elected to office:

<i>President</i>	C. BARRUS CEPPI, M.D.
<i>First Vice President</i>	JOSE RAMOS, M.D.
<i>Second Vice President</i>	DONALD B. FLETCHER, M.D.
<i>Secretary</i>	FRANK J. LOGLER, M.D.
<i>Treasurer</i>	EDWARD ZAMIL, M.D.
<i>Councillor</i>	JOHN M. MALONE, M.D.
<i>Delegates</i>	PHILOMEN P. CIARLA, M.D.
	ANTHONY T. CARRELLAS, M.D.
<i>Censors</i>	NORMAN MACLEOD, M.D.
	DANIEL SMITH, M.D.

Meeting adjourned at 9:40 P.M.

Respectfully submitted,

DONALD B. FLETCHER, M.D., *Secretary*

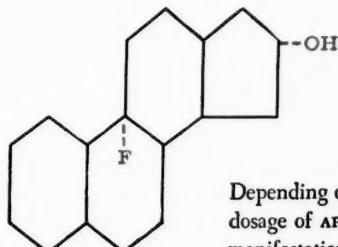
Golf Tournament and Annual Dinner

Wednesday, June 4

Providence Medical Association

The Achievement in Respiratory Allergies: "Good to excellent" results in 29 of 30 patients with chronic intractable bronchial asthma at an average daily dosage of only 7 mg.⁶... Average dosage of 6 mg. daily to control asthma and 2 to 6 mg. to control allergic rhinitis in a group of 42 patients, with an actual reduction of blood pressure in 12 of these.⁷

The Achievement in Other Conditions: Two failures, 4 partial remissions and 8 cases with complete disappearance of abnormal chemical findings lead to characterization of ARISTOCORT as possibly the most desirable steroid to date in treatment of the nephrotic syndrome.^{8,9}... Prompt decrease in the cyanosis and dyspnea of pulmonary emphysema and fibrosis, with marked improvement in patients refractory to prednisone.^{10,11,12}... Favorable response reported for 25 of 28 cases of disseminated lupus erythematosus.¹³



Depending on the acuteness and severity of the disease under therapy, the initial dosage of ARISTOCORT is usually from 8 to 20 mg. daily. When acute manifestations have subsided, maintenance dosage is arrived at gradually, usually by reducing the total daily dosage 2 mg. every 3 days until the smallest dosage has been reached which will suppress symptoms.

Comparative studies of patients changed to ARISTOCORT from prednisone indicate a dosage of ARISTOCORT lower by about $\frac{1}{3}$ in rheumatoid arthritis, by $\frac{1}{3}$ in allergic rhinitis and bronchial asthma, and by $\frac{1}{3}$ to $\frac{1}{2}$ in inflammatory and allergic skin diseases. With ARISTOCORT, no precautions are necessary in regard to dietary restriction of sodium or supplementation with potassium.

ARISTOCORT is available in 2 mg. scored tablets (pink), bottles of 30; and 4 mg. scored tablets (white), bottles of 30 and 100.



LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER NEW YORK

MEDICAL LIBRARY AT RHODE ISLAND HOSPITAL*continued from page 145*

ing up the index need not be a burdensome task, if only a few references are added daily. For a hospital medical library, where time is frequently "of the essence," such a list is both useful and practical.

Work of the Librarian

With all the literature that is constantly pouring in, it is obvious that someone must be responsible for receiving it, cataloguing it, and making it available for the doctors who wish to see it. This is the "housekeeping" side of the librarian's job, but there are other aspects of her work that are just as important. (We refer to the librarian in general as "she," because most hospital librarians are women. However, there is no reason why men should not be attracted to this field.) Actually, her job can be one of the most interesting in the hospital, and will be as rewarding as she cares to make it. She has access to the medical literature, which is fascinating to watch. She has opportunities of working with doctors and other hospital personnel who are stimulating people to know; she has the privilege of attending medical conferences and assisting in research that is a challenge to her ability and resourcefulness. It is not necessary that she should have studied medicine, although some premedical courses are useful, but she must be interested in it and must familiarize herself with medical terms if she would succeed at her job. If the library is to be organized and run so that it will be of most benefit to the medical staff, the librarian must have had basic training in library science, must know how to catalogue books, teach the use of indexes, prepare bibliographies, and know how to approach research problems. In addition to this, she must arrange for the binding of journals, for interlibrary loan, and for photostating or translating of material, if needed. Typing is a most useful "adjunct," and if she can read any foreign languages, so much the better. She cannot be a perfectionist—not in a hospital library—and she must learn to steer a middle course between those who want her to break all the rules for them, and those who would criticize her for breaking any. She also has to decide when she is really helping a doctor, and when she may be hindering initiative. It is good to save the time of the busy practitioner who has so many demands upon him; it is good to provide literature for clinics and conferences to stimulate further reading, but interns and residents, as well as people writing original papers, should be encouraged to do some of their own research. It is our feeling that the librarian should always be willing to guide anyone who needs help in finding material. She should be willing to find references on a given topic for those who have only a little time to spare. She should also be willing to leave no stone unturned

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in the search for elusive material. However, we do not think she should be expected to prepare exhaustive bibliographies covering everything that has been written on a subject, nor should she encourage people to lean upon her so much that they cannot or will not find anything for themselves. We realize that this is a matter of judgment, rather than of strict rule, but fortunately, we have had very little difficulty in convincing people of the wisdom of our policy. It is a privilege to be part of a research team, but getting bogged down in the making up of long bibliographies could soon become mere drudgery, with no time left for anything else. (Naturally, we are speaking here of what should be expected of a librarian as part of her job. If she wishes to work on special projects for individual doctors on her own time, that is another matter.) In summary, if the librarian loves her work, she will find it most rewarding, and if she is interested in people, she will probably be happier in a hospital library (where reference questions are related to patients) than in a large impersonal medical center. Her education (like the doctor's) must go on. Attending medical conferences, lectures and clinics should be considered not only a privilege, but a duty, if she wants to understand the activities that are going on all around her. The realization that her work is also a contribution toward patient care gives inspiration and meaning to her job. This is the basic concept, the ideal of hospital library service that must not be lost sight of.

Relation of the Library to Patient Care

The relationship between library service and care of the hospital patient is an indirect one—through the doctor—but this is quite important. Let us say at once, however, that we do not wish to imply for one moment that doctors could not treat patients without recourse to the literature first. But there are questions that constantly arise, particularly with regard to the use of new drugs, the diagnosis of rare or puzzling diseases, or the use of an unusual surgical technique, where having the literature at hand for reference is most helpful. For instance, physicians on rounds do not always agree as to the diagnosis or the best method of treatment for a particular case. They may want support for their opinions in order to convince their colleagues. Often they will send to the library for a text or journal to verify a statement. Again, interns and residents cannot be expected to know everything about the symptoms of each disease—as, for that matter, who can?—and they are often referred to the library by their more experienced chiefs to read about some particular problem. They can do this and still be on call if needed on their units. This may also work in reverse. Many times, one of the chiefs will come in to see a paper that some enthusiastic resident has noticed in the recent literature

and called to his attention. For medical conferences, journal clubs and clinics, the librarian often puts aside basic reading material—classic papers as well as the most recent reference—to stimulate interest in the subject to be discussed. Doctors with only a few moments to spare will often come in before such a conference to glance through these articles and "brush up" on the type of case to be presented.

The Library in Emergencies

Most of our service falls into a more or less routine pattern, and we make no claim of saving lives or anything heroic, yet there have been instances when having a library on hospital premises* has been essential. Here are a few examples of actual situations that have proved this.

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MEDICAL LIBRARY AT RHODE ISLAND HOSPITAL*continued from page 145*

ing up the index need not be a burdensome task, if only a few references are added daily. For a hospital medical library, where time is frequently "of the essence," such a list is both useful and practical.

Work of the Librarian

With all the literature that is constantly pouring in, it is obvious that someone must be responsible for receiving it, cataloguing it, and making it available for the doctors who wish to see it. This is the "housekeeping" side of the librarian's job, but there are other aspects of her work that are just as important. (We refer to the librarian in general as "she," because most hospital librarians are women. However, there is no reason why men should not be attracted to this field.) Actually, her job can be one of the most interesting in the hospital, and will be as rewarding as she cares to make it. She has access to the medical literature, which is fascinating to watch. She has opportunities of working with doctors and other hospital personnel who are stimulating people to know; she has the privilege of attending medical conferences and assisting in research that is a challenge to her ability and resourcefulness. It is not necessary that she should have studied medicine, although some premedical courses are needful, but she must be interested in it and must familiarize herself with medical terms if she would succeed at her job. If the library is to be organized and run so that it will be of most benefit to the medical staff, the librarian must have had basic training in library science, must know how to catalogue books, teach the use of indexes, prepare bibliographies, and know how to approach research problems. In addition to this, she must arrange for the binding of journals, for interlibrary loan, and for photostating or translating of material, if needed. Typing is a most useful "adjunct," and if she can read any foreign languages, so much the better. She cannot be a perfectionist—not in a hospital library—and she must learn to steer a middle course between those who want her to break all the rules for them, and those who would criticize her for breaking any. She also has to decide when she is really helping a doctor, and when she may be hindering initiative. It is good to save the time of the busy practitioner who has so many demands upon him; it is good to provide literature for clinics and conferences to stimulate further reading, but interns and residents, as well as people writing original papers, should be encouraged to do some of their own research. It is our feeling that the librarian should always be willing to guide anyone who needs help in finding material. She should be willing to find references on a given topic for those who have only a little time to spare. She should also be willing to leave no stone unturned

RHODE ISLAND MEDICAL JOURNAL

in the search for elusive material. However, we do not think she should be expected to prepare exhaustive bibliographies covering everything that has been written on a subject, nor should she encourage people to lean upon her so much that they cannot or will not find anything for themselves. We realize that this is a matter of judgment, rather than of strict rule, but fortunately, we have had very little difficulty in convincing people of the wisdom of our policy. It is a privilege to be part of a research team, but getting bogged down in the making up of long bibliographies could soon become mere drudgery, with no time left for anything else. (Naturally, we are speaking here of what should be expected of a librarian as part of her job. If she wishes to work on special projects for individual doctors on her own time, that is another matter.) In summary, if the librarian loves her work, she will find it most rewarding, and if she is interested in people, she will probably be happier in a hospital library (where reference questions are related to patients) than in a large impersonal medical center. Her education (like the doctor's) must go on. Attending medical conferences, lectures and clinics should be considered not only a privilege, but a duty, if she wants to understand the activities that are going on all around her. The realization that her work is also a contribution toward patient care gives inspiration and meaning to her job. This is the basic concept, the ideal of hospital library service that must not be lost sight of.

Relation of the Library to Patient Care

The relationship between library service and care of the hospital patient is an indirect one—through the doctor—but this is quite important. Let us say at once, however, that we do not wish to imply for one moment that doctors could not treat patients without recourse to the literature first. But there are questions that constantly arise, particularly with regard to the use of new drugs, the diagnosis of rare or puzzling diseases, or the use of an unusual surgical technique, where having the literature at hand for reference is most helpful. For instance, physicians on rounds do not always agree as to the diagnosis or the best method of treatment for a particular case. They may want support for their opinions in order to convince their colleagues. Often they will send to the library for a text or journal to verify a statement. Again, interns and residents cannot be expected to know everything about the symptoms of each disease—as, for that matter, who can?—and they are often referred to the library by their more experienced chiefs to read about some particular problem. They can do this and still be on call if needed on their units. This may also work in reverse. Many times, one of the chiefs will come in to see a paper that some enthusiastic resident has noticed in the recent literature

and called to his attention. For medical conferences, journal clubs and clinics, the librarian often puts aside basic reading material—classic papers as well as the most recent reference—to stimulate interest in the subject to be discussed. Doctors with only a few moments to spare will often come in before such a conference to glance through these articles and "brush up" on the type of case to be presented.

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for all the references that they want to see, much of their reading wouldn't be done. As to whether they make use of the library, our records show that during the past year approximately one thousand questions were submitted to the librarian. This figure does not include work done by individual doctors, which cannot be tabulated. To anyone who questions the need for a medical library in hospitals, this should be convincing evidence.

Problems — Library Hours and Unauthorized Borrowing

If a hospital library is to be of use to the medical staff, it must be available when they need it. In a busy metropolitan hospital or teaching center such as ours, this is likely to be at all times, or twenty-four hours a day. But there are bound to be periods (especially late at night and in the small hours of the morning) when there is no one to supervise the library. How can reference material be made available at those times, yet still be protected from loss through unauthorized borrowing? Various hospitals try to solve this problem in different ways, some by an overnight sign-out system, some by locking up the library and leaving the key where doctors may borrow it, some by having students or volunteers on duty evenings and week ends. Each hospital must work out this problem in the way best suited to its needs. Perhaps our experience in this matter may be helpful.

Our library is in constant use both day and night. Twenty-four hour, or even twelve-hour supervision has not been possible, and locking it up is most inconvenient for everyone. We dealt with the problem of unauthorized borrowing by placing the matter squarely in the hands of the interns and residents through their House Officers' Association. After much discussion, the boys agreed that they really wanted and needed a good library; also that no librarian could be expected to stay if they would not respect rules; and that it was not fair to ask the administration to appropriate funds to replace missing books, merely for the private ownership of careless or selfish individuals. Consequently, they put themselves voluntarily on the honor system, pledging that, if the library were kept open at all times, they would not take books or journals away from it without special permission. Anyone who refused to cooperate or was antagonistic, would be interviewed privately by a special Committee on "persuasive" measures. The Library Committee gladly accepted their promise, and from that time on, our losses have been minimal. We, on our part, began to provide duplicate copies of basic texts in some of the specialties that might be borrowed for study, and we also agreed to purchase some expensive books that we had hitherto been reluctant to buy. All this happened more than three years ago, but the system is still working well. New interns

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and residents are informed of our policies when they first arrive, and so far, they have been willing to respect and accept them. We certainly make no claim that nothing is ever missing, but our records bear favorable comparison with those of libraries that are fully supervised. And the advantage of having the library open at all hours for reference far outweighs the small losses that we have sustained. To some people, this solution of our problem may seem too idealistic. We can only say that it has worked here, and that we can certainly recommend it for trial.

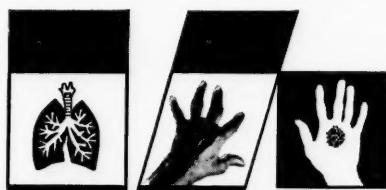
The Medical Staff

Since the visiting men have access to the library of the Rhode Island Medical Society for material that they want on loan, they are not expected to borrow from us. This is their own rule, and experience has shown the wisdom of it. They themselves prefer that books and journals belonging here should not leave hospital grounds. Most of them subscribe to the literature that they wish to see regularly; other material can be put aside for them on reserve, to be read here, or a photostat copy can be made of a paper that they may want for their private files. As for the relation between the library and the medical staff, the encouragement and support that they have given to our work has been unfailing. We owe them much more than can be recorded here. Through their staff association they have made liberal contributions toward the purchase of new books and the binding of our journals. Individual physicians have also made us generous gifts, in some cases valuable sets of bound volumes from their own libraries. Working with doctors has been stimulating and instructive—even an inspiration at times when we realized the importance of what they were trying to accomplish. In fact, we would say that the experience of helping them is one of the most practical ways for a medical librarian to get her training. Formal courses may lay the groundwork, but the very best teachers are the doctors themselves.

This, then, is our medical library at Rhode Island Hospital; these are the concepts by which it operates. It is not the creation of any one person or group of persons. All of us, working together have tried to make it a useful part of the hospital's program, and a contributing factor in patient care. Many changes have occurred since our first library in 1868. Many more will come before 1968. But no matter what form the library of tomorrow may take, if we hold to the principles of service that have guided us in the past, we may look to the future with confidence.

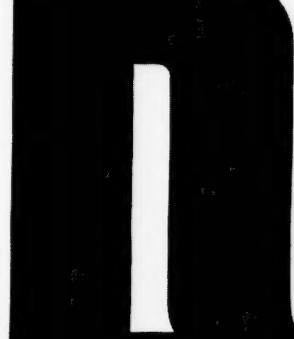
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**HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY**

Report of Meeting held on January 29, 1958

A MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library, Providence, on Wednesday, January 29, 1958. The meeting was called to order by the president, Doctor George W. Waterman, at 8 P.M. The following delegates were in attendance:

Bristol County: Ulysse Forget, M.D. *Kent County:* Peter C. Erinakes, M.D.; Edmund T. Hackman, M.D.; Russell P. Hager, M.D. *Newport County:* Henry Brownell, M.D.; Charles A. Serbst, M.D. *Pawtucket District:* Robert C. Hayes, M.D.; Earl F. Kelly, M.D.; Harold A. Woodcome, M.D.; Hrad A. Zolzman, M.D. *Washington County:* James A. McGrath, M.D.; Samuel Farago, M.D. *Woonsocket District:* Joseph A. Bliss, M.D. *Officers of the RIMS (other than delegates):* George W. Waterman, M.D.; Francis B. Sargent, M.D.; Thomas Perry, Jr., M.D.; John A. Dillon, M.D. *Immediate Past President of RIMS:* Charles L. Farrell, M.D. *Providence Medical Association:* Charles J. Ashworth, M.D.; Irving A. Beck, M.D.; Alex M. Burgess, Jr., M.D.; Bertram H. Buxton, Jr., M.D.; Wilfred I. Carney, M.D.; Francis H. Chafee, M.D.; William B. Cohen, M.D.; Harry E. Darrah, M.D.; Michael DiMaio, M.D.; William J. H. Fischer, Jr., M.D.; Frank D. Fratantuono, M.D.; J. Merrill Gibson, M.D.; John F. W. Gilman, M.D.; Seebert J. Goldowsky, M.D.; Stanley Grzebien, M.D.; John C. Ham, M.D.; Joseph Hindle, M.D.; Walter S. Jones, M.D.; Ernest K. Landsteiner, M.D.; Joseph G. McWilliams, M.D.; William S. Nerone, M.D.; Francis W. Nevitt, M.D.; Arnold Porter, M.D.; William A. Reid, M.D.; Louis A. Sage, M.D.; William J. Schwab, M.D.; James J. Sheridan, M.D.; Stanley D. Simon, M.D.

Also present was the executive secretary, John E. Farrell, and several members of the Society not delegates.

REPORT OF THE SECRETARY

Doctor Thomas Perry, Jr., secretary, noted that his report had been submitted to the House in advance of the meeting.

Action: It was moved that the Report of the Secretary as submitted in the handbook to the dele-

gates be received and that the actions of the Council noted therein be approved. The report of the Secretary is incorporated as part of the official minutes of this meeting. The motion was seconded and adopted.

Recommendations from the Council

The secretary reported that the Council recommended that

1. The official representatives of the Society on the Board of Directors of the Rhode Island Blue Cross for 1958 be Doctor Charles J. Ashworth and Doctor Charles L. Farrell.

Action: It was moved that the recommendation be adopted. The motion was seconded and passed.

* * *

The Council recommended that

2. A proposal for certain surgical fees as requested by the Crippled Children's Division of the State Department of Health, as follows:

For repair of cleft lip \$150 per operation

For repair of cleft palate \$150 per operation
be submitted to the House of Delegates for its consideration.

Action: It was moved that the recommendation be adopted and the fees as noted therein be approved. The motion was seconded and adopted.

Annual Report of the Treasurer

The president noted that the annual report of the treasurer for the year 1957 was included in the handbook submitted to the delegates.

Action: It was moved that the annual report as submitted be approved and placed on file. The motion was seconded and adopted.

Nominees for Physicians Service Board of Directors

The secretary noted that there were four (4) nominations to be made by the House of Delegates of the Corporation of Physicians Service for Directors to serve three-year terms on the Board of Directors of the latter Corporation.

The following were placed in nomination: Charles L. Farrell, M.D., Pawtucket; Henri E. Gauthier, M.D., Woonsocket; Frank Logler, M.D., Newport; Frederick Eckel, M.D., Westerly; Frank D. Fratantuono, M.D., Providence.

Action: It was moved that the nominations be closed. The motion was seconded and adopted.

* * *

On a written ballot Doctors Farrell, Gauthier, Logler and Eckel were elected as directors of Physicians Service to serve until the annual meeting of the Corporation in January, 1961.

* * *

Recess

The president announced that the House of Delegates would recess in order that the annual meeting of the Corporation of the Rhode Island Medical Society Physicians Service might be held. Recess was at 8:35 P.M.

* * *

House Reconvenes

The House of Delegates was reconvened at 10:15 P.M.

* * *

Report on Medicare Program

The president noted that a summary of the present status of the medicare program had been included in the handbook submitted to the House of Delegates. He asked for a decision on the questions submitted in this report.

Doctor William A. Reid reported on the medicare conference held by representatives of eleven (11) states at Atlanta, Georgia, in January.

The subject was discussed at length.

Action: It was moved that the Medicare Committee of the Society as named by the president negotiate with the Office of Dependents' Medical Care for a program in Rhode Island to be operated on an indemnity basis, and also that the Society pledge its complete assistance to the Office of Defense and to the Office of Dependents' Medical Care in the operation of such an indemnity program by establishing a special Professional Advisory Committee to advise and assist the government as appropriate on matters within the scope of the program.

Report on Service Benefit Programs

A motion was made that the policy be adopted by the House of Delegates that there be no further extension of service benefit plans as regards the Physicians Service program. The motion was seconded.

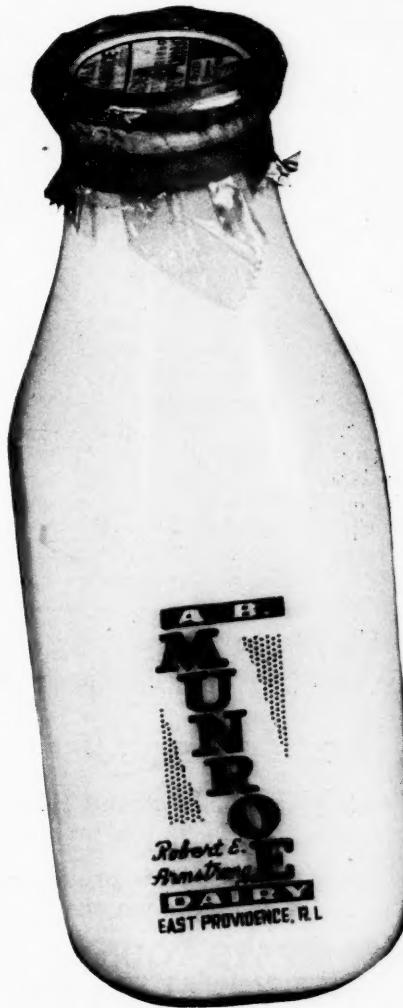
The motion was overwhelmingly defeated on a division vote.

Proposed Radiation Protection Act

Doctor Ernest K. Landsteiner reported on the suggested State Radiation Protection Act, copy of which had been submitted to the delegates in their handbook. He explained the reasons for such legis-

continued on next page

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lation and he reported that the Council of the Society had appointed a committee to consider the legislation and make recommendations. He stated that the committee consisting of himself, Doctor Forsythe, and Doctor Robert Rosin recommends that the House of Delegates request the State Atomic Energy Commission to incorporate in the suggested Act the following:

1. A provision that nothing shall be contained in the Act to restrict the use of radiation equipment or radio active isotopes in the practice of medicine nor would anything be contained in the Act to interfere in any way in the practice of medicine.
2. That provision be contained in the Act relative to the inspection of radiation equipment owned and used by physicians to provide that the inspection be done by a health physicist adequately trained who would be in the employment of the State Department of Health or by a properly qualified health physicist chosen by the individual physician to inspect his equipment at his own expense, with all reports to be filed with the State Department of Health.
3. That complaints relative to the radiation equipment owned and used by physicians be referred to a medical radiation protective advisory committee of five members appointed

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by the Director of Health from a list of ten physicians nominated for such a committee by the House of Delegates of the Rhode Island Medical Society.

4. That nothing in the regulations shall be construed to limit the kind and amount of radiation that may be intentionally applied to a person for diagnostic or therapeutic purposes by, or under the direction of, a doctor of medicine.

Action: It was moved that the report of the Radiation Protection Committee and the recommendations submitted be adopted. The motion was seconded and passed.

Chapin Hospital Report

The president noted that the recommendations of Doctor Anthony J. Rourke, hospital consultant who was retained by the state to survey the future of Chapin Hospital, had been submitted to the House of Delegates in their handbook.

Doctor Hannibal Hamlin, with the permission of the House, discussed some of the recommendations that had been submitted. Doctors Thomas Perry, John C. Ham and Russell Hager also discussed the report, and in particular the problem of housing contagious disease cases in the various hospitals of the state.

Action: It was moved that the president be authorized to appoint a committee to study and consider all aspects of the Chapin Hospital situation. The motion was seconded and adopted.

Report on Osteopathic Legislation

Doctor Charles L. Farrell discussed the proposed amendment to the Osteopathic Licensure Regulations in Rhode Island. He noted that the complete file on the legislation had been submitted to the Delegates in their handbook.

He reported that the amendment as proposed by the Rhode Island Osteopathic Society had been passed this day by the Rhode Island Senate.

Action: It was moved that the report on the osteopathic legislation be received and placed on file. The motion was seconded and adopted.

Report from Washington County Medical Society

The president noted that the report from the Washington County Medical Society of actions taken at its meeting on October 9, 1957, had been submitted to the delegates in their handbook.

Action: It was moved that the report be received and placed on file. The motion was seconded and adopted.

Report of Child School Health Committee

The president noted that the report on Child School Health had been submitted to the delegates in their handbook.

continued on page 164

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HOUSE OF DELEGATES*continued from page 162*

Action: It was moved that the report be placed on file. The motion was seconded and adopted.

Report of Maternal Mortality Committee

The president noted that the report on maternal mortality had been submitted to the delegates in their handbook.

Action: It was moved that the report be placed on file. The motion was seconded and adopted.

Report of Veterans Affairs Committee

The president noted that the report on Veterans Affairs had been submitted to the delegates in their handbook.

Action: It was moved that the report be placed on file. The motion was seconded and adopted.

***Regulations Regarding Insurance Coverage
of Blood Transfusions***

Doctor Thomas Perry briefly reported on a resolution adopted at a joint meeting on December 11, 1957, of the Blood Bank Committee of the Society, the Rhode Island Blood Bank Directors Association, and the Rhode Island Society of Pathologists, copy of which had been submitted to each member of the House.

Action: It was moved that the resolution as submitted regarding insurance coverage of blood transfusions be adopted. The motion was seconded and adopted. The resolution was made part of the official minutes of the meeting.

Adjournment

The president declared the House adjourned at 11:45 P.M.

Respectfully submitted,

THOMAS PERRY, JR., M.D., Secretary

* * *

REPORT OF THE SECRETARY

The Council has held two meetings since the last assembly of the House of Delegates. Major actions taken included the following:

1. The Veterans Affairs Committee was authorized to hold a dinner meeting with representatives of the American Legion, the Disabled Veterans, and the Amvets.

2. The Council suggested that the Committee on Scientific Work consider Newport as a possible place for the Interim Meeting in 1958, and that a date in September be considered.

3. The chairman of the Industrial Health Committee was named as the Society's official delegate to the National Industrial Health Conference sponsored by the American Medical Association, to be held in Milwaukee in January.

4. The executive secretary was appointed the Society's representative on a special committee of the Pollution Information Committee of Rhode Island.

RHODE ISLAND MEDICAL JOURNAL

5. The secretary was instructed to remind the district medical societies, through their secretaries, that the State Society looks with disapproval on physicians of any component societies who have been giving mass inoculations contrary to the policy adopted by the Society.

6. The president was authorized to appoint a committee of three to meet with representatives of the Rhode Island Osteopathic Society to discuss legislative amendments proposed by that Society, and report back to the Council.

7. The Council continued a special committee named to assist trustees of a local union welfare fund in matters of health and medical care for its membership.

8. A proposed health examination program submitted by the Division of Public Assistance of the State Department of Social Welfare was disapproved, and the Society's Committee on Social Welfare was instructed to discuss the Council's position with Welfare Department officials.

9. A resolution relative to the free choice of physician under the Medicare program of the federal government was approved, and the Society's delegate to the American Medical Association instructed to present the resolution at the A.M.A. Clinical Session at Philadelphia.

10. The secretary was instructed to extend an invitation for a proposed New England Regional Medical Library Association to use the facilities of the Rhode Island Medical Society for a regional meeting in 1958.

11. The president was authorized to appoint a committee to investigate and to report to the House of Delegates on a proposed Radiation Protection Act for Rhode Island.

12. A resolution from the Rhode Island Society of Pathologists was approved and the Council requested the Division of Professional Regulation of the State Health Department to enforce the statutes whereby clinical laboratories would be prevented from reading Papanicolaou slides for cancer diagnosis, and engaging in any other phase of medical practice.

13. Legal counsel of the Society was authorized to represent the Society officially at a medical-legal conference to be conducted by the American Medical Association in Chicago in May, 1958.

14. The Council voted to express the appreciation of the Society to the American Medical Association, Brown University, the Rhode Island Department of Education, and the Providence School Department for their co-sponsorship with the Society of the outstanding health education lecture series held at Brown University in the fall of 1957.

15. The president was authorized to name a committee of three to be advisory to the Rhode Island Chapter, American Physical Therapy Association.

16. Approval was given the request for cooperation of the Society of a study of lung cancer deaths to be conducted by the Federal Department of Health, Education and Welfare jointly with the Rhode Island Department of Health.

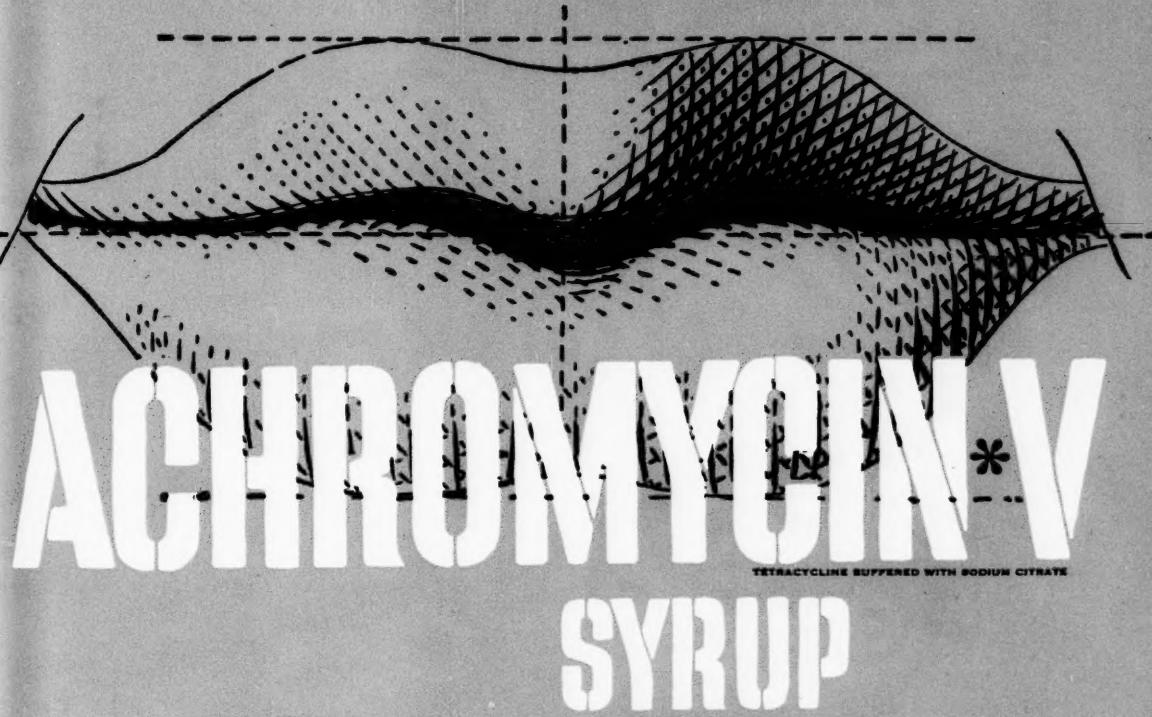
17. The president was authorized to appoint a committee to consider medical problems of the aging.

18. A resolution drafted by representatives of eleven states, including Rhode Island, at a special meeting in Atlanta, Georgia, urging joint support of a petition to the appropriate Congressional Committees and the Secretary of Defense to permit negotiation of an indemnity program at the time of renewal of Medicare contracts was unanimously approved. (See resolution attached to Medicare Report.)

19. The annual report for 1957 of the treasurer was received, reviewed and approved.

continued on page 166

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FAST-ACTING
ORAL FORM
OF CITRATE-BUFFERED
ACHROMYCIN V**



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ACHROMYCIN V*

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- unsurpassed, true broad-spectrum action
- minimal side effects
- well-tolerated by patients of all ages

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DOSAGE:

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Lederle

HOUSE OF DELEGATES

continued from page 164

20. A resolution from Newport County Medical Society endorsing Doctor Arthur King of Adamsville as "Rhode Island Doctor of the Year" was voted to be placed on the agenda of the April meeting of the House of Delegates, and the Secretary was instructed to invite any other component Society desiring to nominate a physician for such an honor to submit such nomination prior to April.

21. The Chapin Hospital Study Report was reviewed and referred to the House of Delegates for its consideration.

THOMAS PERRY, JR., M.D., *Secretary*

* * *

Report of the Treasurer

The complete financial records of the Society have been examined by Ward, Fisher and Company, certified public accountants. All receipts were traced into the bank and canceled checks were examined and checked to disbursement records. Cash on deposit was confirmed by the bank. Totals of duplicate deposit slips were verified and checked to ledger accounts recording the various classifications of receipts. All ledger account additions were verified. Salary checks were summarized for the year, and compared to earnings records and payroll tax returns.

The auditors have reported that in their opinion "the records of the Society are carefully kept and

RHODE ISLAND MEDICAL JOURNAL

are in sufficient detail to properly reflect its financial operations."

A summary of the financial statement for 1957 is as follows:

Cash balance, Checking Account,	
Industrial National Bank,	
January 1, 1957	\$ 9,957.24
Receipts, 1957 (Exhibit A).....	60,580.71
TOTAL	70,537.95
Expenses, 1957 (Exhibit B).....	58,679.27

Cash balance, Checking Account,	
Industrial National Bank,	
January 1, 1958	\$11,858.68

* * *

Total Cash and Invested Assets, January, 1958:

Cash balance, Checking Account,	
Industrial National Bank	\$11,858.68
Investments, Pooled Funds, Trust Department (Exhibit C), Industrial Nat'l Bank, and Uninvested Principal Cash	51,947.00
TOTAL	\$63,805.68

JOHN A. DILLON, M.D., *Treasurer*

* * *

CHILD-SCHOOL HEALTH COMMITTEE

Early in December this committee met with Doctor Donald A. Dukelow of the American Medical Association and invited guests from the Rhode Island Public School System to discuss the question of "what is being done to recognize the gifted child and what is being done for him in Rhode Island." It was the concern of the committee that the Medical Society might be derelict in its duty if we did not recognize the problem and offer our services to the school authorities. This meeting was more or less exploratory and we have offered the services of the committee to the State Department of Health.

The lecture series, jointly sponsored by the Medical Society, Brown University and the State Department of Education, given to school teachers and school nurses successfully ended early in December. Ten recognized authorities gave the lectures. Approximately one half of them were members of our local medical profession.

We anticipate a future meeting with Doctor Glidden Brooks, who is directing the National Institute of Health Grant at Brown University, to investigate the causes of the brain damaged child.

JOHN T. BARRETT, M.D., *Chairman*

* * *

VETERANS AFFAIRS

The Veterans Affairs Committee of the Rhode Island Medical Society met on Thursday evening, 21 November, 1957, at the Biltmore Hotel with two

continued on page 168



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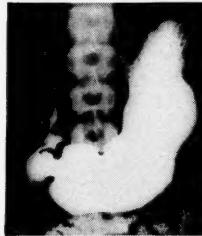


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of the
Providence Medical Association**

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HOUSE OF DELEGATES
continued from page 166

representatives of the American Legion, Mr. Walter Hyde and Mr. Frederic Browning, and two members of the Disabled American Veterans, Mr. Maurice Pion and Mr. Rush. Following dinner, an informal question and answer period with everyone participating was carried on for approximately one hour.

It was neither our purpose, nor desire, to pressure our theories and beliefs on our guests, but rather to ascertain their point of view on the problem of the non-service connected veterans' hospitalization.

While they agreed that there were abuses, both on the veterans' side of the problem as well as from the medical side, they were definitely of the opinion that the government owes the veteran medical care, whether it be for service connected or non-service connected disabilities. The tone of the meeting was friendly throughout, and we felt that it was worthwhile to meet with them to discuss any future problems that our committee, or any other committee of the Medical Society, might have pertaining to them.

RICHARD P. SEXTON, M.D., Chairman

* * *

MATERNAL MORTALITY COMMITTEE

This committee met on April 30, 1957, at which

RHODE ISLAND MEDICAL JOURNAL

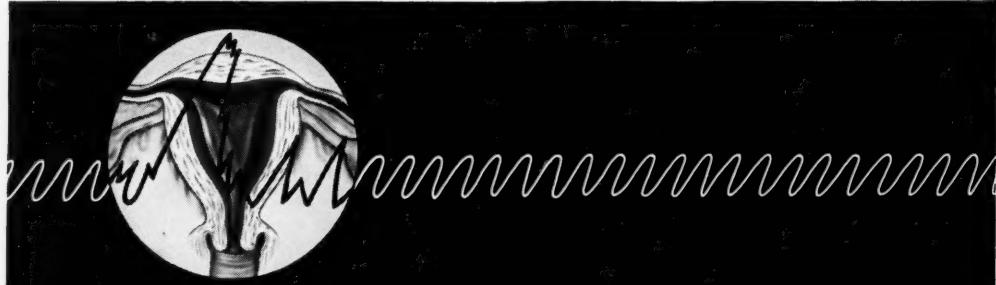
time the ten maternal deaths during the year 1956 were analyzed and discussed thoroughly. Because of the small number of deaths, which is the lowest in the history of the state in spite of the largest number of births, it was felt that the individual case histories should not be published at this time, but that we would wait until we had accumulated a group of cases for a period of perhaps three years. In so doing, we might insure anonymity of the cases and parties involved and have a larger number of cases and causes which would have more statistical significance. Because the statute of limitations is two years in this state and because of the increasing tendency to malpractice suits, we feel that caution is essential in publishing any medical reports of this nature. There has always been some resistance in obtaining accurate case records for this committee because of fear of litigation. However, we do seem to be having less difficulty as the years go by, and the educational value of these studies to the profession has become more apparent.

The major causes of death in the ten cases were as follows:

	<i>Cases</i>
Pneumonia	3
Eclampsia	1
Rupture of uterine artery.....	1
Septic abortion	1
Myasthenia gravis	1

concluded on page 170

in dysmenorrhea



Pavatrine® with Phenobarbital

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- relaxes the hypertonic uterus thus relieving pain
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Dosage: one tablet three times a day beginning three to five days before onset of menstruation.

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Bottles of 100 tablets.

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HOUSE OF DELEGATES
concluded from page 168

	<i>Cases</i>
Intestinal obstruction	1
Severe burns	1
Multiple fractures, hemorrhage and shock from auto accident	1
These were classified as :	
Obstetrical	3
Non-obstetrical	6
Preventable	2
Non-preventable	7

One case was unclassified due to insufficient data. It is interesting to note that pneumonia which is supposedly a curable disease in these days was the major cause of death.

During the past year, the Council on Medical Service of the American Medical Association has published A GUIDE FOR MATERNAL DEATH STUDIES. This will enable the different states and maternal mortality organizations to have more uniform and accurate statistics for their studies. It has been difficult in the past to compare statistics because of the lack of unanimity of opinion as to what constitutes a maternal or an obstetrical death. According to our report, we have an obstetrical mortality rate of 1.5 per 10,000 births which compares favorably with the national average of 3.8 per 10,000.

Emphasis in the past has been on the prevention of maternal mortality. With this reaching an almost irreducible minimum, we must now turn to reduction of maternal morbidity as well. This has a direct effect on perinatal mortality which should be our next project. Rhode Island is a small state with a concentrated population. It would be quite easy to initiate such a study here. Your chairman with Dr. William Bell recently attended a special meeting on perinatal mortality in Philadelphia in December, 1957, held the day before the American Medical Association convention there. There were representatives from a large number of the states present. It was very revealing to learn that so many cities, counties, and states already had such committees functioning. These committees were usually composed of an equal number of obstetricians and pediatricians with perhaps a consulting anesthesiologist and pathologist. It would seem with the small number of deaths to investigate now that the Society might consider either changing the name of this committee to a Committee on Maternal and Perinatal Mortality or appoint an entirely new Committee on Perinatal Mortality.

STANLEY D. DAVIES, M.D., *Chairman*

RHODE ISLAND MEDICAL JOURNAL

**RESOLUTION REGARDING INSURANCE
COVERAGE OF BLOOD TRANSFUSIONS**

WHEREAS, private national insurance carriers (and until recently the Blue Cross of Rhode Island) are offering provisions in their hospitalization insurance plans for cash payment of hospital blood transfusion charges, and

WHEREAS, the present donor recruitment methods employed by Blood Banks in Rhode Island are successful largely through the stimulation to blood donation resulting from the use of a penalty fee system (the present hospital charge for blood is made up partly of a service fee to cover expenses, and largely of a penalty fee which can be canceled by replacement of blood by volunteer donors) and

WHEREAS, the insurance coverage provides cash payment of all transfusion charges including the penalty fee, and

WHEREAS, the widespread adoption of such insurance carrier blood payment provisions would in effect abolish the penalty fee system and with it our successful volunteer blood donor programs, and

WHEREAS, the blood bank success in this area is in direct relation to the percentage of volunteer donors obtained, therefore

BE IT RESOLVED, that the Rhode Island Medical Society be strongly urged to join with its own Blood Bank Committee, and with the Rhode Island Blood Bank Directors Association, and the Rhode Island Society of Pathologists, in voicing disapproval of this type of insurance provision which is potentially very detrimental to the health and welfare of the people of Rhode Island.

It is recommended further that notice of this combined disapproval be forwarded by the Council of the Rhode Island Medical Society to Blue Cross of Rhode Island and to the State Commission of Insurance Carriers.

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—Pope

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—Chapman

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